CLINICAL MEDICINE

ORIGINAL ARTICLES

AUTHORITATIVE INDEPENDENT PRACTICAL

FEBRUARY 1948

Vol. 55 No. 2

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OF NEMBUTAL'S CLINICAL USES

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SURGICAL
Preoperative Sedation
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Postoperative Sedation

PEDIATRIC
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Blood transfusions
Administration of parenteral fluids
Reactions to immunization procedures
Minor surgery

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GEORGE B. LAKE, *Publisher* RALPH L. GORRELL, M.D., *Editor*

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Reentered as Second Class Matter October 19, 1940, at the Post Office at Waukegan, Ill., under Act of March 3, 1879. Additional entry as Second Class Matter August 1, 1942, at the Post Office at Wilmette, Ill.

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1. Gusberg, S. B., Am. Jl. Obst. & Gyn. 50:502, 1945.

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**A Clinical Study of 180 Cases of Arthritis—Magnuson, P.B., McElvenny, R.T., and Log C.E.—J. Michigan State Med. Soc. 46:71 (January) 1947.*

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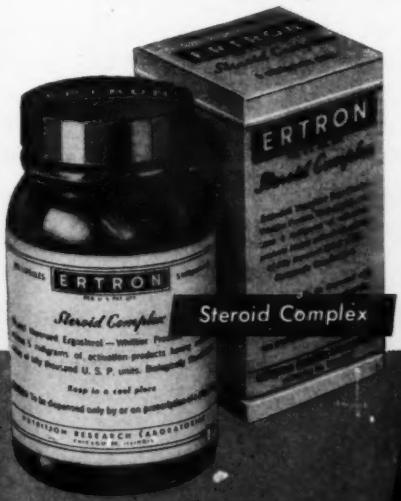

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CLINICAL MEDICINE

FEBRUARY, 1948

Volume 55, No. 2

ORIGINAL ARTICLES, NOTES, AND REPORTS:

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Clinical Notes and Abstracts

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*Fishberg, A. M.: Heart Failure, Lea and Febiger, Phila., 1946, p. 733.

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The Problem of the "Blue Sky" Note

"Cash is simply out of the question," the Michigan patient declared.

"And so is waiting any longer," Dr. Medico informed him.

"Now, I'll tell you what I can do, and all I can do," the patient averred. "Here's Henry White's note in my favor for $1,000, and that will pay your bill and leave $275 to good. The note has only three months to run, I'll endorse it to you, you receipt the bill, and pay me the difference."

"Endorse the note quick," Dr. Medico agreed, and reached for his receipt book.

Dr. Medico's willingness to accept this proposal was due to his knowledge that White was perfectly good for ten times the face of the note, but, when it fell due, White refused to pay, and Dr. Medico was forced to sue.

"The note was given for a stock in a corporation, and the stock was sold to me contrary to the Michigan Blue Sky Law," White proved in Court, and his lawyer contended that the note could not be collected.

"That would be true, if the payee of the note (the patient) were suing White, but it doesn't apply to a case like this where Dr. Medico took the note before it was overdue, in good faith, for value, and without any knowledge of the circumstances," Dr. Medico's lawyer retorted, and the Michigan Supreme Court upheld his contention in a case reported in 194 N. W. Reporter, 553.

"This would undoubtedly have been a good defense as between the parties to the note, but when the note passes to the hands of a bona fide holder, that defense cannot and ought not to be raised," was the reasoning of the Court.—Judge M.L.H.

Subclavian Surgery

To the Editor:

In reference to the July *Industrial Medicine* and the article on "Subclavian Structures—A Practical Approach to Their Surgery." We have been resecting the clavicle in many of our cases in which it was necessary to get at the brachial plexus and subclavian vessels. We have not attempted to reconstruct the clavicle as Drs. Hanson and Hoyt which has given quite satisfactory results. There is no question that the incision and approach, which Drs. Hanson and Hoyt have used, will give excellent exposure.— ALTON OCHSNER, M.D.

"Our future will depend on whether God is on our side." True, Brother; but also in whether we are on His side.— Fountain Inn Tribune.

The New Salesman and the Physician

To the Editor:

An article in *American Business* for April 1947 attracted my eye. It comments on the former belief that salesmanship was a "fight" to win attention and to convert the prospective buyer, and the present attitude that a buyer and salesman join hands and work together for mutual understanding, mutual agreement and mutual profit. Any other type of salesmanship is a short term deal, a "catch 'em once" proposition.

Some physicians treat patients who enter their office on the "once in, never see again" basis and endeavor to sell an operation, a treatment or other services by frightening the patient or making strongly worded statements. Often they succeed, for the time being. In the long run, they lose the patient; the patient

THE AURICLE SPEAKS

loses the confidence he held in the profession, and rightly so.

The physician should explain to the patient the exact condition found, be perfectly frank in stating if more observation, consultation or study is needed before a correct diagnosis can be reached. He should outline the various courses of treatment that are to be pursued and reasons for each (except in emergencies where only one course is best). In other words, the Golden Rule is still a pretty good one. He will find many patients will stick with him for years, because they have learned that he tells the truth.

I enjoy the Auricle, and only wish that more men would get off their private gripes and views.—M.B., Ark.

Posterior Pituitary Preparations

Pituitary preparations have been offered as "pitressin" the antidiuretic portion and "pitocin" the oxytocic factor. Clinical studies indicate that pitocin is often ineffective.—RICHARD TORPIN, M. D. in *J.A.M.A.*, July 26, 1947.

Treatment of Undulant Fever (Brucellosis)

To the Editor:

Most of the cases treated in our service come on the late stages of the acute phase and among them we use the treatment with our soluble antigens. The basis of this method relies on the assumption that brucellar infection continues in spite of the immunity acquired after the acute phase because of the intracellular growth of Brucella. (A paper of mine on pathogenesis of brucellosis is expected to appear soon in the *Proc. Soc. Exp. Biol. and Med.*) This growth stimulates the state of immunity further until hyper-sensitivity becomes a real trouble. Therefore, most of the clinical manifestations of the subacute and chronic phases are likely due to the immune reactions.

Under such conditions we use our antigen aiming to "desensitize" the patients. Our antigen acts as a hapten, has no effect on normal individuals but produces allergic reactions in patients. We find this method well tolerated

(Continued on next page)

THE AURICLE SPEAKS

(Continued from page 11)

and has given us better results than the use of vaccines. However, we fail to obtain results when the infection is complicated by previous or simultaneous secondary infections. It is necessary to remove dental foci and tonsils soon. Chronic cases in our experience are benefited by desensitization provided that the patients respond to the antigen, which is easily determined by the skin test. So far, we have treated over 1,000 patients with subacute and chronic brucellosis. The treatment is some cases is spectacular but one must not hope to see result in less than a few weeks and the average duration of the treatment in chronic cases is usually 10 weeks.—M. RUIZ CASTANEDA, M.D., General Hospital, Mexico City, Mexico.

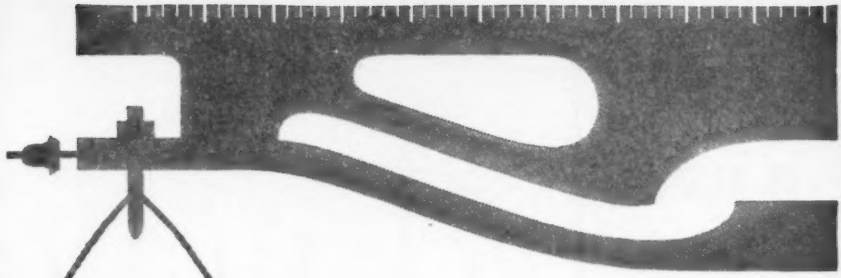
Hansen's Disease

To the Editor:

It was very thoughtful of you to send us a copy of the July issue of *Clinical Medicine* in which you carried mention of the work being done by THE STAR. We appreciate your interest and trust that from time to time you will give your readers more information about Hansen's disease (leprosy). Not long ago Dr. Fennel, formerly Associate Professor of Pathology of the University of Illinois, while visiting us here said, "There is no use educating the public about Hansen's disease until you educate the doctors." We think that Dr. Fennel hit the nail right square on the head, and we feel that medical magazines should devote some space to discussing Hansen's disease.—*U. S. Leprosium, Carville, La.*

"I am Different"

A young woman lived under very discordant conditions at home. She was dissatisfied, and her discontent was manifest in her face, her manner and the tone of her voice. Trifles irritated her in this disagreeable environment. Some time after a friend met her and saw in her smiling face that a change had taken place. "How are things at home?" he inquired. "Just the same," was the reply, " but I am different."—*Christian Endeavor World.*



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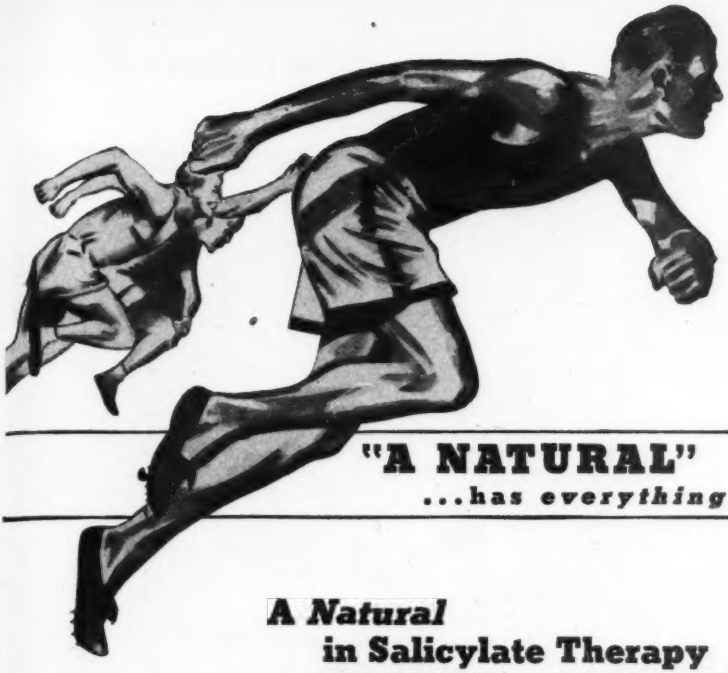

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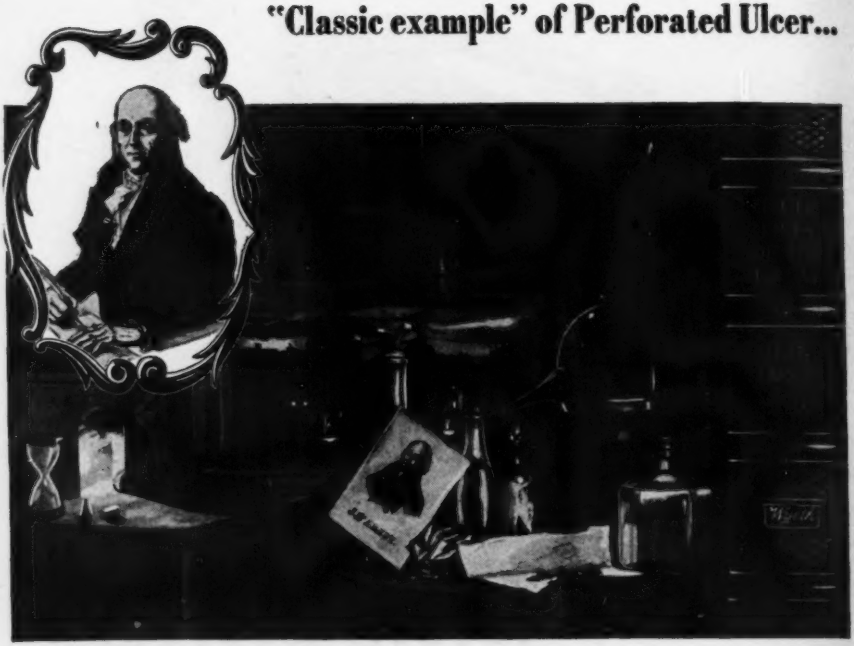

JEAN D'ARCET, chemist and physicist of 18th century France, is cited as one of the first recognized cases of perforated peptic ulcer (in Cruveilhier's *Pathological Anatomy of the Human Body*).

D'Arcet's symptoms appeared only at the age of 72—diarrhea, often with epigastric or colicky pain. He died suddenly about six months after suffering had become acute. Autopsy revealed two ulcers on the lesser curvature of the stomach, one with indurated edges and three perforations, the largest of which was 6-7 mm. in diameter.

If D'Arcet could have had the benefits of today's medical knowledge, with modern antacid therapy, he might instead be the classic example of a severe case restored to health by intragastric drip treatment.

PHOSPHALJEL is ideal for drip therapy in bleeding or refractory cases; orally it is excellent for marginal as well as uncomplicated ulcers. Phosphaljel effectively reduces the acidity of at least five times its own volume of gastric juices; and it inactivates pepsin even in a highly acid medium. Phosphaljel lays a protective coating over the inflamed mucosa, permitting continuous healing without further corrosion.

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Infectious Hepatitis

By PERRIN H. LONG, M.D.

Johns Hopkins University School of Medicine, Baltimore, Maryland

INFECTIOUS jaundice or hepatitis has been a scourge of armies for hundreds of years. In World War II it was especially prevalent in the Mediterranean area causing a high morbidity and a steadily increasing mortality rate. Infantry men were most affected of any Army group and the riflemen especially so.

Prior to this war, our knowledge of infectious hepatitis was quite limited. In fact, certain textbooks still in print will refer to catarrhal jaundice as a mild disease without permanent after-effects, probably due to catarrhal inflamation of the bile duct.

There is a prodromal state with or without jaundice. Many cases will not show clinical jaundice. The cases of acute hepatitis may relapse with jaundice or may become chronic hepatitis.

Types

There is a common type of infectious hepatitis which has an acute course with jaundice in which clinical recovery takes place in approximately six weeks. There is a mild type without jaundice and, third, a protracted, chronic type of hepatitis which may be characterized by remission and relapse. Because there were many thousand cases of infectious hepatitis in the Mediterranean area, during the war, one should be sure in questioning veterans concerning their exposure in those theaters and especially if they had jaundice at any time.

The symptoms include those of the prodromal period which gradually pass over into those of the frank disease itself, including anorexia, headache and right upper quadrant aching, followed by jaundice. One rough test for determining the prodromal stage whether hepatitis is present, is to have the patient jump up and down for several minutes. A large tender lymph node may be found posterior to the sternocleidomastoid muscle, in many cases. The spleen is enlarged in 80 per cent of the patients. Percussion with the fist under the right costal margin or in the right costal vertebral angle usually results in pain referred from the liver. Another way of determining liver tenderness is to have the patient bend over, take a deep breath, while the observer who has encircled the patient with his arm from the rear, pulls up under the right costal margin of the patient.

There is a moderate leucopenia with relative lymphocytosis. Abnormal lymphocytes may be found which resemble those seen in infectious mononeucleosis. Early in the disease the sedimentation rate is normal. It may increase at the

time that jaundice appears or at the time of recurrences. As a test it is of little value.

Bromsulfalein Test

This is one of the best tests for liver dysfunction if jaundice is *not present.* Five milligrams of bromsulfalein per kilogram of body weight are injected intravenously. A blood sample is removed at the end of 45 minutes. If there is 8 per cent or more of retention, the patient should be kept in bed. Full activity should not be resumed until the test is normal.

Causes of Infectious Hepatitis

A filterable agent which resists normal chlorination and the half hour heat of 55 degrees Centigrade is apparently the cause of infectious hepatitis. Unsanitation is another factor, as the agent apparently is spread by feral contamination. It may be water or food borne. Flies may spread the disease. The agent appears in the blood and stools during the acute stage of the disease. The incubation period of the epidemic disease is commonly from 15 to 30 days.

Homologous Serum Jaundice

One must differentiate homologous serum jaundice which occurs after the administration of blood products contaminated by the filterable agent, the virus. Human blood serum and plasma have contained the agent. It may be spread by needles which are not sterilized, as well as by syringes which have not been properly sterilized. All needles should be boiled before being used. They should never be used twice without boiling. It was found that multiple doses with the same needle may cause the transmission of this virus.

Treatment

Treatment of the acute stage of infectious hepatitis includes:

1. Absolute bed rest in bed until the jaundice has disappeared and the icteric index is approximately normal.

2. A high protein, very low fat, high carbohydrate diet. The patient should gain weight during the course of treatment. These patients will eat if given the proper food. (Most fatty foods are slightly rancid and may tend to upset the appetite of the patient. This is the only reason for decreasing fat in the diet.)

3. The patient is not allowed to get up until the bromsulfalein is 8 per cent or less. If it is above this level, many patients will suffer a relapse when they get up prematurely. After the patient is up there must be an exercise tolerance test before he returns to work.

In determining the ability to get up, one should examine the liver the last thing in the afternoon, as the liver may be palpable and tender in the afternoon and yet have been negative in the morning.

Results

Of the patients in the Mediterranean Theater of Operations with infectious hepatitis 92 per cent were returned to full duty; 4.2 per cent were returned to limited duty; 3.3 were returned to the United States as they were not completely recovered in 90 to 120 days; 0.21 per cent died.

Conclusions

Catarrhal jaundice is the same disease as infectious hepatitis. This disease may have been brought home from all over the world, in various strains.

Those states which require the reporting of jaundice are finding many more cases than formerly.

Up to six relapses have been recorded. The treatment is the same as in the first attack.

A veteran patient may be in the chronic, inactive stage with indigestion and lassitude, which seem to resemble psychoneurosis. One should always ask such a veteran if jaundice or hepatitis occurred in his outfit.

Homologous serum jaundice occurs

from blood and blood products, or needles which have been contaminated with the virus of hepatitis. Donor must not have a history of recent jaundice. Needles and syringes should always be sterilized before being used.

Pain is the fire alarm of danger, but stopping the alarm does not put out the fire.

Methergine: Its Use in the Induction of Labor

By E. P. FARBER, M.D.
Philadelphia, Pennsylvania

EVERYONE engaged in the practice of obstetrics has at some time found it necessary to induce labor. The use of castor oil, quinine, hormones, pituitary extract alone or in combination with rupture of the membranes, tamponade of the lower uterine segment and vagina, insertion of a hydrostatic bag or bougie has not been found to be wholly satisfactory. In addition some of these methods are fraught with great danger.

Recently Stoll and Hoffmann[1] have isolated a new synthetic ergot preparation designated as Methergine, which has been found to be very satisfactory as well as safe for the induction of labor. Methergine may be given orally as well as parenterally. Its action is more certain when used parenterally than orally. It can be used equally as well on those cases in which the membranes are intact as in those in which the membranes are ruptured.

In a recent study on the use of Methergine in the induction of labor, I was able to induce, successfully, 27 out of 30 consecutive cases[2]. The majority of these had unruptured membranes and a cervix which was uneffaced. All of these women were induced by giving Methergine orally. There were no ill effects on the mother or baby, and the length of labor was markedly shortened.

I have also obtained excellent results using Methergine subcutaneously for the induction of labor in women with intact membranes. An article on the subject will be published later on.

The indications for the induction of labor are principally maternal, but may be fetal or both. The principal maternal indications are toxemia of pregnancy, pernicious vomiting, intrauterine fetal death, and premature rupture of the membranes. The fetal indications are post maturity and polyhydramnios. Under maternal and fetal indications can be listed premature separation of the placenta and placenta previa.

Routine induction of labor is not advocated. Under normal circumstances the spontaneous natural onset of labor is to be desired but the indications previously set forth are in reality complications of labor and it may be injudicious to wait for labor to begin spontaneously under such circumstances.

The use of such a relatively safe and efficient method, by helping to overcome some of the most trying complications of pregnancy, may become a safe and valuable addition to the obstetrician's armamentarium.

1829 Pine Street.

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Errors in General Practice

(GRADUATE COURSE)

THESE answers contained in letters written to a number of men interested in special fields concerning the common mistakes made by general practitioners as regards their field, reveal many useful and beneficial pointers.

Psychosomatic Disorders

In the field of psychosomatic disorders, the diagnosis of heart disease is often made because the patient complains of palpatation and irregularity of the heart beat, which are due to anxiety.

Gastric manifestations of anxiety are mislabeled as "peptic ulcer".

The cause of nervous fatigue is often not recognized as emotional turmoil, but is diagnosed as many other conditions.—DR. LOUIS A. GOLDEN, *Neuro Psychiatrist*, Ochsner Clinics, New Orleans.

Lesions

The lesions which I think have been frequently misdiagnosed by the general practitioner have been malignant disease of the colon, bronchogenic malignancies, peripheral arterial diseases, particularly those which are incipient, and bronchiectasies. All these conditions are frequently encountered and yet, are frequently not diagnosed until the condition is quite far advanced. It is particularly unfortunate in malignant lesions because of the progressive nature of the lesion.—ALTON OCHSNER, M.D., Chief of Surgery, Tulane University Medical School, New Orleans, La.

Hoarseness

General practitioners, as a rule, are fairly adequate in their diagnosis in otolaryngology, except that a few of them fail to realize the significance and dangers of persistant hoarseness. Laryngologists see too many cases that have been treated over an extended period of time, or else ignored by the general practitioner. Fully 40 per cent of cases of carcinoma of the larynx reporting to the laryngologists are so far advanced that little or nothing can be done for them, and I feel that this percentage can be greatly reduced by winning the full cooperation of the general practitioner.—FRANCIS E. LEJEUNE, M.D., Ear, Nose and Throat, Ochsner Clinic, New Orleans, La.

Urinary Infections

There are several topics that we attempt to emphasize in connection with the postgraduate work given to general practitioners here at Tulane University. Chief among them are conditions in the genito-urinary tract that complicate urinary infections, conditions of the female bladder and urethra that produce urinary symptoms and that are not necessarily associated with infection in the urine, the importance of early recognition of congenital deformities of the genitor-urinary tract, and the signifi-

cance of hematuria.—EDGAR BURNS, M.D., Ochsner Clinic, New Orleans, La.

Bronchitis, Bronchiectasis and Asthma

A diagnosis of chronic bronchitis is frequently made by the general practitioner, and no effort is made to find out whether it is really bronchitis, whether the patient has tuberculosis, neoplasm of the lung, chronic sinusitis, or some other cause for the chronic cough.

Bronchiectasis is very frequently misdiagnosed or undiagnosed merely because the doctor does not take a careful history and think of bronchiectasis.

Asthma is commonly diagnosed when a patient wheezes, whether the cause be due to allergic manifestations or due to some localized bronchial obstruction. We see cases of tuberculosis of the tracheobronchial tree, and of neoplasms of the bronchus which have been treated for asthma because of unilateral wheezing.

Tuberculosis

Most general practitioners are confused about the diagnosis of primary type of pulmonary tuberculosis. This diagnosis is frequently made on the basis of a positive tuberculin test, with or without evidences of calcification in the lungs and hilum. After calcification has appeared the primary type of tuberculosis is, of course, usually a healed lesion. The actual danger period during which primary tuberculosis is active is usually brief and unobserved. Parents of children are needlessly alarmed by the doctor making a diagnosis of primary tuberculosis after the danger is passed.—JULIUS L. WILSON, M.D., Internist, *Ochsner Clinic*

X-Ray

It goes without saying that no doctor knows enough. No human brain can assimilate all the relevant clinical facts, but I believe that the good American doctor is above par in his theoretical education and clinical knowledge. He also uses x-ray and laboratory facilities more extensively—and perhaps depends too much on them.—ALBERT MUELLER-DEHAM, M.D., New York City.

Chest Pain

The failure to recognize and give adequate attention to a typical chest pain even of very minimal character. The electrocardiogram is not used widely enough in cases of retrosternal discomfort. The differential diagnosis from nerve root pain, neurosthenia, gastrointestinal disturbances, and so forth, have recently been discussed in the Journal of the American Medical Association in a very adequate article.

Dizziness

A common error is to handle elderly patients with cardiovascular disease or generalized arteriosclerosis for the complaint of dizziness. Almost every week, we find one with fainting attacks or dizzy spells who have these attacks on the basis of carotid sinus sensitivity. This is commonly left out of consideration even in patients over age 70. They are presumably "supposed to have these attacks" because they are elderly and have cardiovascular disease.

X-Ray

A common error in diagnosis is the result of too much reliance on x-ray findings with reference to the gastrointestinal tract lesions. Many of these patients after a gall bladder visualization, short gastro-intestinal x-ray series and barium enema are discharged with the statement that nothing is wrong. This is further exacerbated in the so-called "neurotic" patient. Many of these cases will come to light if they are subjected to an exploratory laparotomy when the symptoms are unexplained on the basis of demonstrable lesions.

Anemia

There is a great tendency among physicians and surgeons to treat moderate or even severe anemias with iron and liver preparations without adequate

explanations of the basis of the anemia. Sometimes such a search even leads to rib resection before an accurate diagnosis can be established.

Heart Disease

A common error on the part of a physician is to classify practically all heart disease as "some type of heart ailment, or some type of heart murmur." Specific diagnosis and in most instances etiologic diagnosis is of extreme importance in establishing the nature of a cardiac lesion. Frequently the general practitioner confuses a simple premature contraction with organic heart disease. Cardiac arythmias are by and large more poorly handled than any other type of common cardiac abnormalities.—SAMUEL B. NADLER, M.D., Internist, New Orleans, La.

[The general practitioner's greatest failing today is to take a full history and perform a complete physical examination, on many of his patients.—Ed.]

Thyroid Nodules

One of the most common mistakes I see made is the complacency with which the average general practitioner and often the internist regard nodules of the thyroid gland. The incidence of malignancy developing has increased tremendously in our department in the last decade and it is now somewhere between 10 and 15 percent in my own private practice. I think no one can be no more certain a nodule in the thyroid gland is benign or malignant from mere palpation than one can say in an early breast tubor, and that all nodules in the thyroid gland should be considered potentially malignant until proved otherwise.

Gall Stones

Another common mistake has to do with gall bladders, particularly in older women when a round cholesterol stone or two that is not faceted is picked up in the gall bladder in the routine examination and the physician informs the patient, that a gall stone is there, but that they are having no symptoms and to leave it alone. All the cases of carcinoma of the gall bladder that I have seen have had gall stones, and last, but not least, practically all of the acute gall bladders that I have seen have been due to these cholesterol stones about the size of an olive becoming impinged in the goose-neck, shutting off the circulation of the cystic artery and vein and thus causing the gall bladder to become distended.

I think these stones should be removed even if the gall bladder is not taken out. They are different from the infectious stones and metabolic in origin, but can be the cause of a very disastrous clinical situation if they become blocked in the goose neck.—WILLIAM F. RIENHOFF, JR., M.D., Baltimore, Md.

Surgical Problems

I have great respect for the diagnostic and therapeutic ability of most general practitioners and have found them increasingly more able in their evaluation of what surgery could accomplish. My answers to your question are entirely generalizations but I would state three errors as follows:

1. Underrating the possible accomplishment of surgery in able hands.

2. Overrating the dangers of surgery in able hands.

3. Delay in getting honest surgical opinion about a possible surgical lesion.

By underrating possible accomplishment in able hands I mean the fear of surgery more than it deserves. For example, carcinoma of the rectum, surgery can accomplish a great deal in salvaging lives and restoring the patient to normal even in the matter of reestablishing continuity, in many of these patients at the present time. Yet, it is my impression that when the general practitioner encounters such a case he often believes all is lost, and this at-

titude may delay strong advice to the patient to go immediately to an able surgeon.

In overrating dangers, the same example could be used, or for example, complicated peptic ulcers, obstruction, or repeated hemorrhages. The mortality from surgical procedures for these is extremely low and in reality is and should be less than the dangers of the lesion which the patient harbors, but in many instances the general practitioner fears that the mortality would be extremely high and thus delays surgery.

In the third instance a delay in getting *honest* surgical opinion might apply to breast tumors or obstructive jaundice. Time lost may mean the loss of the life of the patient. Honest, as an adjective, is used advisedly to indicate that I think a surgeon must not only be technically skillful, but must have the judgment that is best for the patient, turning them down as surgical problems, when that is indicated and accepting them only when surgery can offer them more than conservative management. Too often a high powered individual may advise surgery simply because the patient has been sent to them and because there is some excuse for doing it. It is my feeling that careful surgical judgement is a rare attribute. But there are enough honest surgeons so that the general practitioner need not fear asking for a surgical opinion regarding any lesion. Surgeons should not be so enthusiastic about their field that they will be unable to evaluate conditions accurately and give a true conclusion.

These answers may not be those you desire, for example; delay in the diagnosis of appendicitis, delay in the diagnosis of lumps in the breasts, and incomplete rest and care of post-thrombophlebitic edema, leg ulcers, leg injuries, and so on. The answers, I feel, can be more accurately stated as generalizations. It is true that delay of many things may be of harm, but the amount of harm must be the true evaluation of how serious the delay is.—HOWARD MAHORNER, M.D., New Orleans, La.

What helps the individual patient most is to be taken as the best treatment for him, whether it be possible or not to analyze its action in every detail.—Wenckebach.

Sensitivity to Thiamine Hydrochloride

The possibility of hypersensitiveness to thiamine hydrochloride must be considered in any patient to whom this vitamin is to be given parenterally. Truly allergic reactions occur in which a patient first tolerates a substance which later produces a mild or severe systemic reaction and the presence of antibodies may be demonstrated by means of passive transfer to a nonsensitized individual. Reactions to thiamine are more frequent than indicated by the number of published reports. When practical, thiamine should be administered orally: in the rare case where parenteral administration is necessary, the patient should be hyposensitized.—H. T. ENGELHARDT, V. C. BAIRD, *Annals Allergy*, 291, July-Aug. 1946.

Clinicopathologic Conference (Case 12)*

A 17-YEAR-OLD school girl entered the hospital because of swelling of the ankles and fever.

Previous history: Fig. 1. When three years old, she had acute appendicitis followed by arthritis, which moved from joint to joint, a heart murmur and chorea, for which she was kept in bed for 6 months.

Fig. 2. At age seven, a second attack of arthritis involved several joints in succession, without cardiovascular signs or symptoms. Her health was then good for many years.

Fig. 3. While swimming, she twisted her right leg; the pain disappeared after manipulation. This occurred at age 16 years and 6 months.

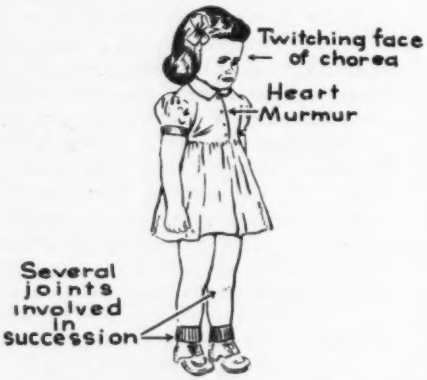


Fig. 1. Age 3

HISTORY

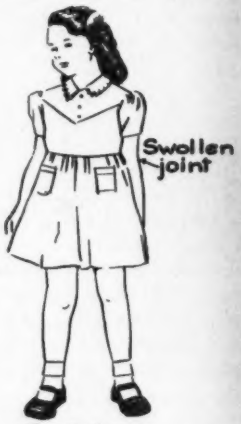


Fig. 2. Age 7

Fig. 3. Age 17

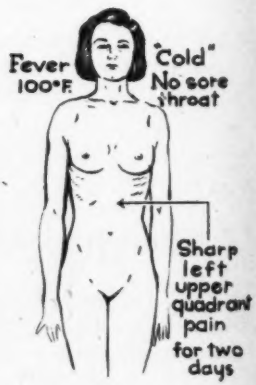


Fig. 4

Fig. 4. Fever of 100° F., an apparent "head cold" and sharp pain in the left upper quadrant of the abdomen lasted for 2 days.

Fig. 5. One month later, she was in the hospital because of fever. Sulfadiazine and penicillin immediately relieved it.

Fig. 6. Fever, muscle aching, cough and swollen ankles appeared two months later. Fever continued for over a month, as did the ankle edema which disappeared after she rested.

Fig. 7. On admission, she complained of nausea, vomiting and "stomach-ache" for 12 hours. Examination revealed patchy erythema on the abdomen, the left border of the heart was 12 cm. to the left of the midline, with the maximal impulse in the fifth interspace; apical systolic thrill; strong mitral first sound followed by a blowing loud systolic murmur; pulmonic second sound greater than aortic; lungs were normal; tip of spleen was palpable but not tender; the liver was not felt; red, punctate, nontender areas on cushion and tip of thumb.

Temperature 100.6° F., pulse 94; respiration 18; blood pressure 130/80; red cell count 3,470,000 with 8.2 Gm. hemoglobin; white cells 21,700 with 82 per cent neutrophiles; urine slight trace of albumin, 25 white and red cells per high power field.

Normal electrocardiogram, heart appeared normal on chest film; fluoroscopy showed enlargement of the left auricle posteriorly; sedimentation rate

Fig. 5

Fig. 6

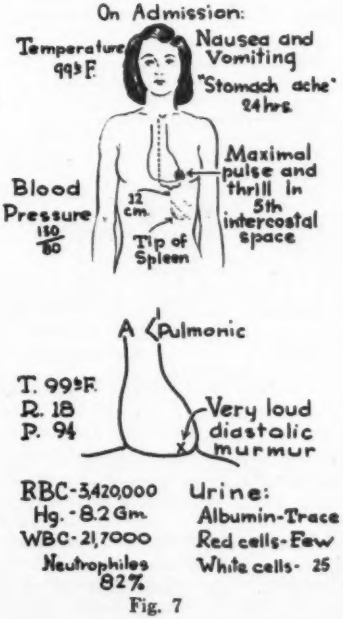


Fig. 7

of .45 mm. (normal, less than 0.35 mm.)

Fig. 8. *Hospital course:* Spiking fever to 104 for a week, then gradual decrease to 100° F. where it remained; positive blood cultures for alpha-hemolytic streptococcus (Group A); unproductive cough and a "stitch" in the left chest, increased by inspiration. A "ground-glass density" appeared in the lower half of the left chest, obliterating the diaphragm and left border of the heart was displaced *toward* the density. Penicillin therapy resulted in disappearance of fever by the fourteenth day; it was continued 33 days for the subacute bacterial endocarditis involving the rheumatic heart.

Fig. 9. On the 33rd day, aching pain occurred again in the left upper quadrant with mild tenderness, and signs of fluid recurred in the left chest posteriorly. There was no change in temperature or pulse; white cell count 20,000 with 73 per cent neutrophiles, 13 lymphocytes, 14 monocytes.

Fig. 10. The following evening, she suddenly clutched the left upper abdomen, vomited, began writhing and groaning; she was pale, sweating, and cold. The breath sounds were equally good on both sides with dullness at the

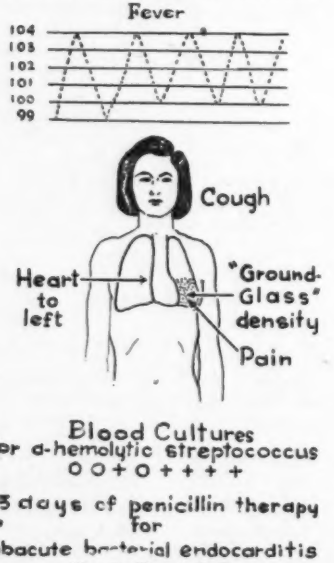
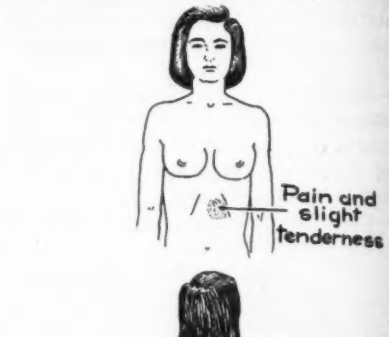
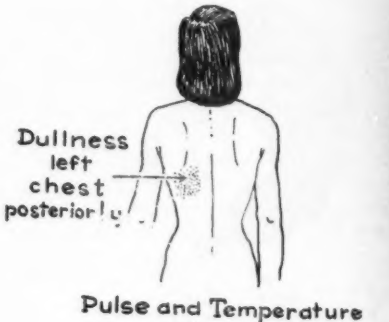


Fig. 8. Hospital Course





Pulse and Temperature unchanged

Fig. 9

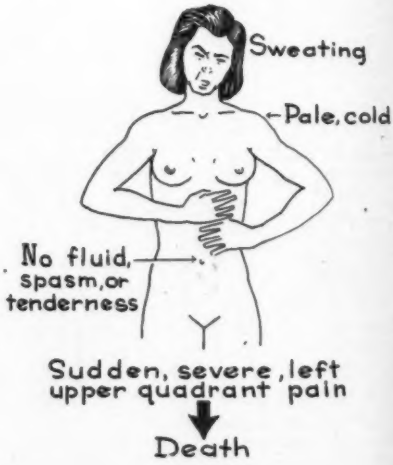


Fig. 10

left base; the trachea was not displaced; the heart sounds were regular and rapid, with unchanged murmurs. The abdomen was silent. Knee jerks were weak and equal. She was using both legs and arms equally well in turning and twisting. She grunted in response to questions. Oxygen slightly improved the color of the skin. Death followed 30 minutes after the onset of this attack.

Clinical Diagnoses: Subacute bacterial endocarditis; pulmonary embolus. Diagnoses suggested by internist who reviewed the history: Subacute bacterial endocarditis; splenic infarcts; spontaneous rupture of the spleen. Your diagnosis: _____.

Fig. 11. *Necropsy findings:* Subacute bacterial endocarditis, splenic infarcts with rupture of spleen and blood filling the entire left abdominal cavity. The heart was only slightly hypertrophied; the mitral valve was markedly thickened and vegetations were superimposed on it. Healing embolic areas were noted in the kidneys. The left lower lobe of the lung was collapsed (atelectasis) and fluid was present in the left pleural cavity.

The heart was drawn to the left by the atelectasis of the left lower lobe, rather than forced to the right by the pleural fluid.

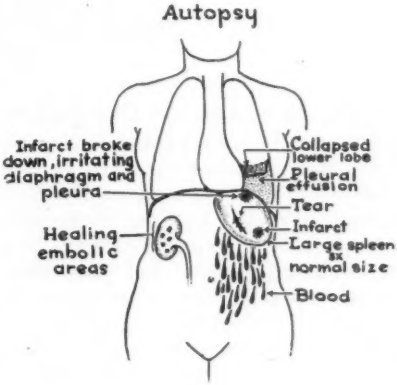


Fig. 11

"Humility must always be a portion of any man who receives acclaim earned in the blood of his followers and the sacrifices of his friends."—Dwight D. Eisenhower.

The "Head-Down" Posture in Anesthesia

The physiological effect of the head-down position in anesthesia is valuable in counteracting depression of certain drugs and in stimulating heart action through increasing the venous return. In head-up posture blood collects in the lower extremities. In addition to improving the circulation by body posture, an increase in the amplitude and rate of respiration is improved. In animal experiments, respiratory arrest following intravenous anesthesia in the head-up position, has been followed by normal respiration when posture was reversed. H. DITTRICK, Anesthesia and Analgesia—p. 176, July-Aug., 1946.

Pointers on Amebiasis and Its Complications, Diagnosis and Treatment

PART II

By DON E. NOLAN, M.D., *and* HARRY WARSHAWSKY, M.D.
Dayton, Ohio

THE clinical picture of intestinal amebiasis is a varied and at times a very vague state, as has been pointed out in Part I of this paper. The complications are in turn far more complex and obscure when one realizes how apparently unrelated they may seem to the initial intestinal site of the pathology. To appreciate the various localizations of the complications, it is well to emphasize that the amebae are carried from the wall of the colon by radicles of the portal system. Commonly the liver is the first organ involved in this spread of the amebic infestation. From this organ, the amebae may invade other viscera by direct extension or less commonly by transmission through lymphatic or blood vascular channels. So we see that it is the liver that is the chief seat of complications, and it is with this organ that this paper will deal in large part.

It should be remembered that dysentery is an infrequent manifestation of amebiasis[1]. Lesions in the large intestine are not invariably found on sigmoidoscopic examination. Therefore despite the absence of a history of dysentery, amebiasis must be considered in the differential diagnosis of many bizarre clinical syndromes. The report of Ochsner, DeBakey and Murray[2] is significant. They studied the stools of 139 patients with amebiasis of the liver and found the parasites in only 30 per cent of them. The complexity of the problem is emphasized by the difficulty of making a diagnosis of hepatitis—in the absence of jaundice or abscess in its early stages.

Liver abscesses due to amebic infection may be single or multiple, acute or chronic. In an analysis of 1000 cases of amebic dysentery, Payne[3] found hepatitis in over 50 per cent and liver abscess in almost 3 per cent. Craig[4] observed liver abscesses in 5 per cent of 745 cases of amebiasis. The term "amebic hepatitis" is used to indicate the early phase of amebic hepatic disease before frank abscess can be diagnosed. Sodeman and Lewis[5] stress the fact that it is impossible to be certain clinically that small single or multiple abscesses are not present during the early phase when diagnosis and treatment are extremely important. Multiple foci of necrosis may coalesce to form a single large abscess. The most frequent seat of the abscess is the upper and posterior portion of the right lobe.[2] It is from this site that abscesses may extend upward and penetrate the diaphragm with rupture into the lung. Again, more medial involvement with extension through the diaphragm has resulted in amebic pericarditis.

Hepatic disease complicating amebiasis usually appears one to three months after an attack of dysentery, but it may manifest itself during an attack or much later[6]. The symptoms of

* Conclusion of a two-part article. Part I appeared in the Jan. 1947 issue of C.M.

hepatic abscess include pain or discomfort over the liver, with occasional reference to the right shoulder, irregular and intermittent fever, sweats, chills, nausea, vomiting, weakness and loss of weight. Jaundice, except in mild degree, is unusual, having been present in Sodeman and Lewis'[5] series of 33 cases in only 15 percent. In four cases recently reported by the authors[6] this sign was absent in all. Diarrhea or dysentery is present in only about a fourth of the cases of proved liver disease.

The diagnosis of hepatic amebiasis depends primarily on a high index of suspicion. Not infrequently a diagnosis of fever of undetermined origin is carried for weeks, because the clinical picture is not specific and the physician does not even consider amebiasis in his differential diagnosis. Liver function studies are not diagnostic[7]. They are merely suggestive and help to point the finger of suspicion at the liver. Leukocytosis of moderate degree is usually present, averaging about 15,000; distinctly lower than the leukocytosis accompanying pyogenic hepatic abscess. Stool examination for amebic cysts is, of course, of paramount importance, but is often negative even in the most competent hands. Of great importance in the diagnosis of this condition is the fluoroscope, which frequently shows elevation of the right leaf of the diaphragm, sometimes of an irregular nature, and limitation of motion. The use of intravenous diodrast and planography has its advocates. In some hands it has been very helpful in accurately localizing the site of a liver abscess. Because of its specificity in amebiasis, emetine constitutes a therapeutic test of great value; but, since the drug is a potent protoplasmic poison, it should be used circumspectly as a diagnostic agent.

It is not uncommon for a patient with acute amebic hepatitis to be referred to the surgeon for a laparatomy because it presents itself as an acute abdominal emergency, such as a ruptured viscus. A careful consideration of the circumstances—the history of exposure to amebic infestation, the enlargement of the liver with distinct tenderness over this organ, the probable presence of even a low degree of icterus, moderate leukocytosis, probable history of dysentery; the finding of amebae in the stools and the characteristic sigmoidoscopic picture of amebic ulceration or both; and finally the awareness of the possibility of acute amebic hepatitis —will make the correct diagnosis. Frequently, the latter is all the physician has to aid him, but it may be enough to prevent needless surgery. The use of emetine hydrochloride given daily in one grain dosage, intramuscularly for 6 to 10 days, will ordinarily, in these cases, bring about distinct improvement so that the suspicion of amebic hepatitis may be substantiated.

Another interesting complication of liver abscess is the presence of a pleural effusion resulting from the inflammation of the diaphragm due to the proximity of the hepatic abscess. This may cause the physician to be led astray, especially if the liver is not significantly enlarged or tender. Sooner or later the picture may become evident. However, the need for accuracy of diagnosis is urgent in just this situation, because it is here that the abscess may rupture through the diaphragm into the pleural cavity and lung. The diagnosis of pleural involvement may be readily made by following up the presence of physical findings of a pleural effusion by thoracentesis and demonstrating the anchovy sauce material withdrawn. This fluid may or may not contain the Endamoeba histolytica. Again, if there are adhesions between the tissues overlying the liver abscess and lung, the rupture may occur directly into the lung. Here one sees the clinical picture of a lung abscess of acute onset, with expectoration of brownish or chocolate colored sputum

containing the amebae in their motile form (trophozoite). The combined presence of amebic empyema and lung abscess is not uncommon. The amebic empyema becomes symptomatic especially when there is superimposed bacterial infection. The incidence of pleuropulmonary complications is not inconsiderable and these should not be brushed aside as being too rare to bear in mind. It should be mentioned while on this subject, that primary amebic abscess of the lung, which would necessitate transmission of the infecting organism by the blood stream is very rare. Here the parasites also pass to the liver through the portal circulation, but they overcome the barrier of the capillaries of the liver and pass into the right side of the heart and, in turn, the lungs. One such case is reported by Brea, Michel and Gamba[8].

Amebiasis cutis is a rare but serious complication of amebic infection. It has followed drainage of liver abscesses, appendectomies, colostomies and colitis.[9] It should be suspected in every case of ulcerating or granulating lesion of the abdominal wall or about the anus and genitalia.

Amebic appendicitis may give rise to the symptoms of acute or chronic appendicitis. The incidence of involvement of the appendix in amebiasis is undoubtedly much greater than statistics would indicate, as many cases are overlooked, especially in individuals who have had no history of diarrhea or dysentery. Craig[10] states that except in emergencies, a careful examination of the stools for this parasite should be made in every case of appendicitis befor resorting to operation. It is particularly in the patient with the well established diagnosis of amebic colitis that one may be able to prevent needless and, possibly harmful surgery.

Other rare complications need be mentioned only in passing. These include amebic brain abscess, peritonitis and cholecystitis. Of more frequent occurrence in the past has been the patient who through inadequate treatment as a rule has suffered repeated attacks of dysentery with resulting replacement of the normal mucous membrane of the colon by scar tissue. This in turn causes chronic diarrhea with its evil train of sequelae.

It has already been mentioned that emetine hydrochloride is the specific therapeutic agent for amebic infections. The judicious use of this drug rarely combined with the indicated surgical procedure will as a rule clear up most amebic complications. The toxic nature of emetine has already been stressed. The general course of treatment should last only 6 to 10 days, and a repeat course should generally not be given in less than 2 to 4 weeks after the first. It is well known that amebic hepatitis in the pre-abscess state will respond to a course of emetine without any surgical manipulation. Even some small abscesses will heal on emetine alone, and it should therefore always be given a trial before surgery is resorted to, unless an emergency is present. However, in the presence of a frank abscess, which can be localized as well as possible by fluoroscopy or more accurately by diodrast and special x-ray studies, emetine by intramuscular route may not be enough. Location of the abscess by the aspirating needle and closed drainage is the procedure of choice. Klatskin[11] lists the indications for aspiration of amebic hepatic abscess with closed drainage as (1) the failure of the patient to show any improvement on adequate emetine therapy, and (2) clinical or roentgen evidence that an abscess located near the surface of the liver is getting larger under emetine therapy. It is the consensus among the authorities that open surgical drainage is fraught with danger, carrying a mortality rate generally believed to be in the neighborhood of 30 per cent.

Whether or not other drugs such as diodoquin, carbarsone, chiniofon, and so on should be used in the treatment of amebic hepatitis is the subject of

considerable disagreement. It would appear wise to follow the short course of emetine therapy by one of the other drugs, not because of the possible effect of these other drugs on the liver pathology per se, but because of the possible presence of associated intestinal infection. Thus Kauffmann[12] follows the emetine treatment of amebic hepatitis by six to nine tablets of diodoquin, an iodine compound, daily for 21 days. It is pertinent to state that despite the voluminous literature which has recently appeared, the treatment of amebiasis varies considerably with the investigator.

Conclusions

The frequent occurrence of complications of intestinal amebiasis is discussed. Amebic hepatitis which is a particularly common complication is stressed. It should be looked for in all service men returned from zones in which amebiasis is prevalent. It is important to realize how bizarre the clinical picture can be. Early diagnosis depends upon constant awareness of its possible existence. In turn, cure depends upon early diagnosis and prompt institution of adequate emetine therapy. Aspiration of unhealed amebic abscesses is rarely necessary, for most of these lesions respond to medical treatment. Open surgical drainage is fraught with danger. Emetine is the specific remedy for other less common complications together with any surgical procedure that good judgment would indicate to be of value.

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Any old chunk can float downstream but it takes a live fish to go upstream.

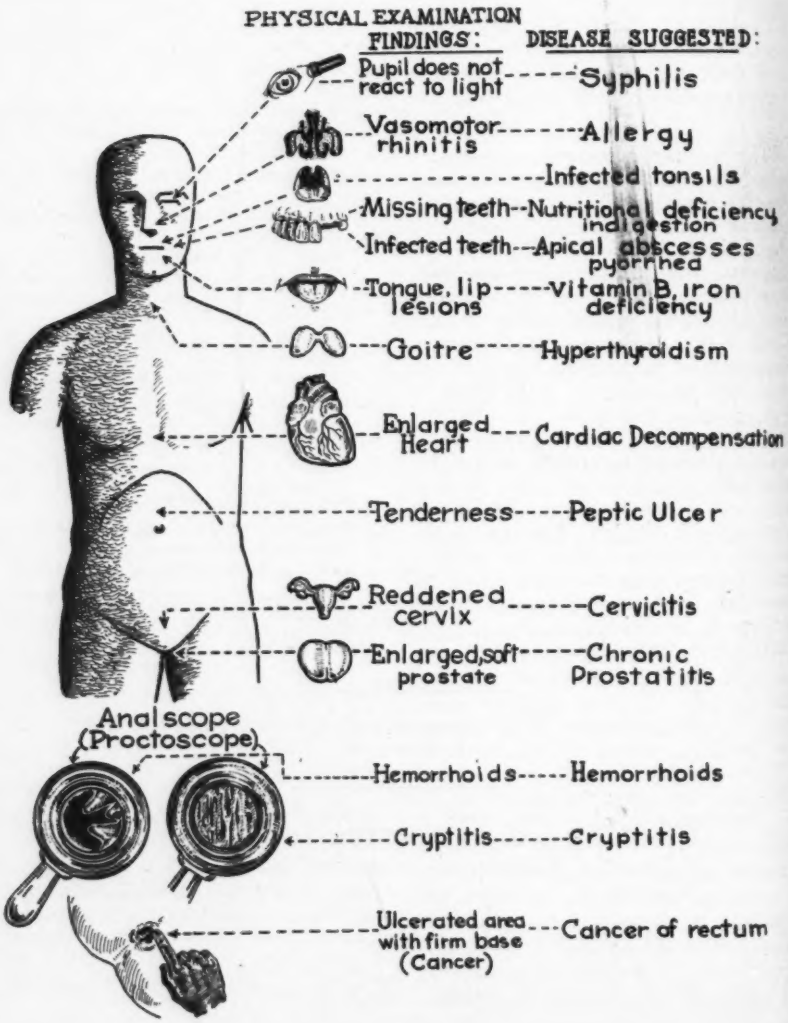
Penicillin in Glycerine for Impetigo

Twenty grams of tragacanth, 200 cc. of glycerine and 200 cc. of water are employed in making up the base. The tragacanth is mixed with 30 cc. of glycerine and added to the remainder of the glycerine. 100 cc. of water are added next. To the remainder of the water 100,000 units of penicillin are added and the whole is mixed throughly. This ointment is most effective when applied at least three times daily to the impetigo.—*U. S. Naval Med. Bull.*, 46:1439. 1946.

Office Study of the Tired Patient

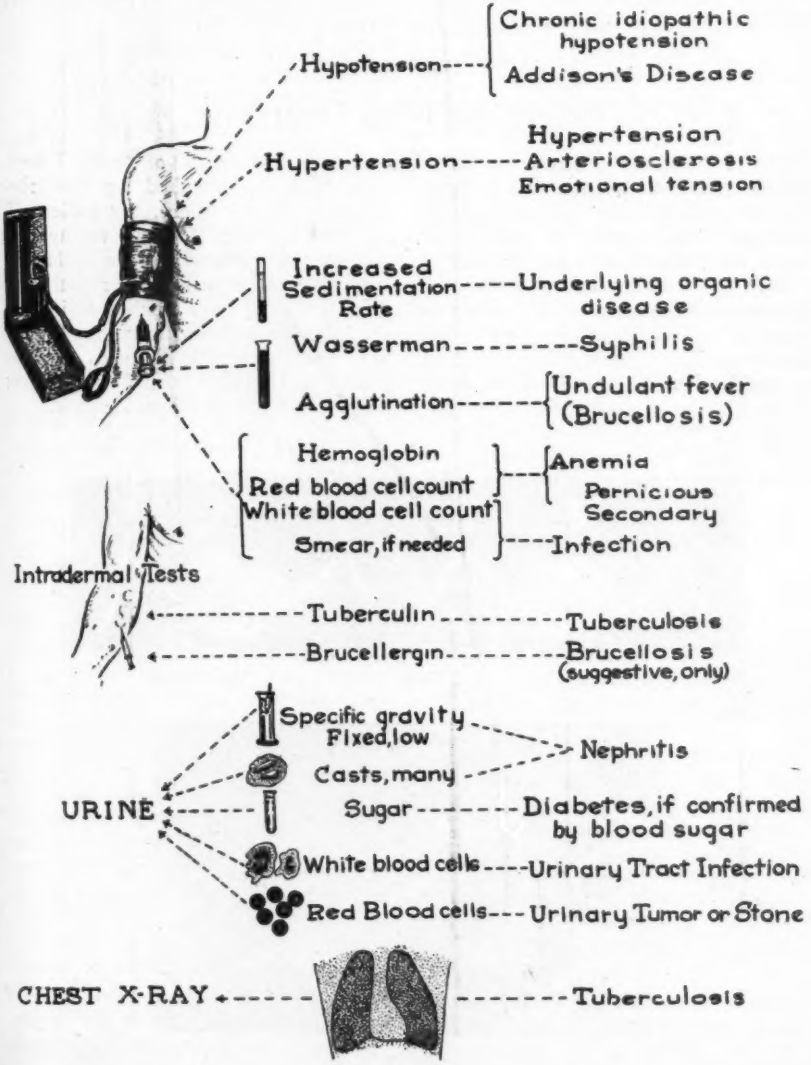
A common problem is the "tired" patient who comes to the physician's office. Such patients are not the same as those who are admitted to hospitals for weakness, because marked signs of disease are usually not present. A perfunctory examination often discloses nothing yet here is the golden time to discover early organic disease.

Clinical Medicine's staff has outlined pictorially a number of causes for fatigue. All examinations, except the



chest x-ray, may be carried out in any physician's office anywhere. The only requisite is enough enthusiasm and interest to study the patient and to jot down notes (to save time, a diagram can be imprinted on history sheets with a rubber stamp and positive findings sketched in).

A complete physical examination is at once a refresher course for the physician in learning the normal and discovering early disease, a means of edu-



cating the patient to what constitutes good medical care and a source of increased practice through treatment of lesions found.

These suggestions are not completely filled out, i.e. the chest x-ray may show other lung diseases than tuberculosis, or cardiac enlargement. They may serve as a reminder to the busy physician of conditions commonly overlooked.

There are many other conditions that cause fatigue: Emotional tension and psychoneurosis which cause a large percentage of the fatigue seen in office practice; menopause; hypothyroidism; calcium deficiency.

Retention With Overflow

The dome of an overfull bladder is usually rounded. In cases of long-standing chronic urinary obstruction, i.e., retention-with-overflow (a condition in which the patient makes but little or no complaint of pain or dysuria), the swelling arising out of the pelvis is wont to be mistaken for some other condition. This frequent error reaches its zenith when the contour of the dome of the bladder is unorthodox (Fig. 1.). Not once, but scores of times, I have seen clinicians beguiled by this phenomenon. For instance, the patient illustrated in (Fig. 2) came to my outpatient clinic bearing the following letter from an experienced practitioner: "Mr. C. has a large tumour filling up the hypogastrium and extending to the left. The remarkable thing is that he looks and feels well."—HAMILTON BAILEY, F.R.C.S., London, England.

Orthodox Fig. 1 Unorthodox

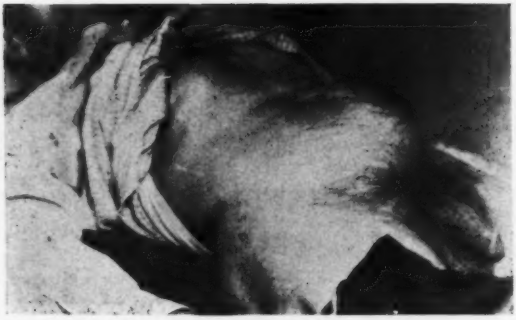


Fig. 2

The Crippled Patient

The physician probably spends as much time solving the personal, family, and social problems occasioned by the illness of his patients as he does in solving their medical problems. This is hardly an original observation, but it serves to introduce the thought that perhaps we, as physicians, could solve some of the former problems more easily, if we would make more use of every possible ally.

There are many agencies, local, state and national, which offer services that might conceivably save much of the physician's time—time which he could devote more profitably to the medical care of his patients. The doctor, busy as he is, cannot be expected to know of all these agencies and services; to have all of them at his finger tips would require him to be a walking directory and social encyclopedia. But it is amazing how much information can be had by the simple stratagem of having the addresses of a few key national or state agencies. A brief letter of inquiry frequently brings in leads that may save a great deal of time both for the doctor and his patient.

One very common problem which confronts the physician is that of the patient, either child or adult, whose injury or illness leaves a residual handicap. If the patient is a child, the chances are that his parents know little or nothing about special services in education, recreation, social services, or vocational training offered either in the state or in the community. They turn to the doctor for information and advice, and few physicians have the time to make exhaustive inquiries on the subject. The same is true of the handicapped youth or young adult. What is he to do about rehabilitation and placement on a job?

In solving these problems the physician has a fairly simple way of getting information not only on procedures, but on the facilities available in this area. A letter to the National Society for Crippled Children and Adults, Inc., at 11 South La Salle Street, Chicago, 3, Illinois, will bring either the desired information, or else suggestions about where it may be obtained.

This organization has more than two thousand state and local member societies. The work of this nation-wide organization is supported by the annual sale of Easter Seals. All the services of the Society are aimed to supplement, not to duplicate, those of other agencies, either public or private.

At the National headquarters there is a free lending library of literature and data on the problems of the physically handicapped. It is probably as nearly complete as will be found anywhere in the world.

The National Society for Crippled Children and Adults also publishes *The Crippled Child* magazine. It is the oldest magazine addressing itself specifically to persons interested in the problems of the handicapped. ($1.00 per year.)

The Society's services are carried out with the professional advice and guidance of medical specialists in the various fields concerned. These medical men serve the Society as counselors.

A problem frequently faced by the busy physician is the necessity of explaining to the distraught parent the nature of his child's affliction. In the case of cerebral palsy, for example, this is a time-consuming process, and without simple graphic material, extremely difficult. However, with the aid of a pamphlet, such as *The Farthest Corner*, for example, issued by the National Society, the physician will find this problem greatly simplified.

The Society welcomes use of its services and facilities by physicians at all times.

Diagnostic Error

By R. L. GORRELL, M.D.

Clarion, Iowa

FOR twenty years the basic reason for a group of symptoms was not known. The patient, a physician, was the son of a specialist and the brother of a physician. Two nationally known ophthalmologists, two otolaryngologists, a radiologist, and internationally famous clinic, and an internist were consulted, regarding various signs and symptoms. Not one of all these physicians considered the case as a whole, considered the individual and his family history.

Course: From the age of ten years on, certain symptoms recurred frequently: 1. Aching in the eyes and forehead; 2. Crampy abdominal distress, frequent bowel movements and anal burning following defecation; 3. Burning on urination; 4. Aching in back and extremities, increased by cold; and 5. Nasal obstruction.

The dull, aching pain in the eyes and forehead was especially troublesome during college days, forcing him to drop out of school for a year. His vision, always markedly myopic, decreased to 20/1,000. A diagnosis of *progressive myopia was made.* This process stopped at age twenty one.

Gastrointestinal Tract

He became accustomed to the attacks of abdominal distress relieved by bowel movement, urgency and burning, during his teens and thought little about them. He was never patiently questioned concerning gastrointestinal symptoms, even when he consulted a well trained internist at age 22. An attack of diarrhea had been followed by expulsion of a small amount of blood. Careful sigmoidoscopy showed no ulcer or neoplasm. Diagnosis:

Dysentery

A typical attack of appendicitis was followed by an appendectomy at age 14.

Urinary Tract

Burning on urination came on intermittently. For no apparent reason, burning would appear suddenly and persist for one-half to several hours, gradually disappearing. Urinalyses never revealed albumin, sugar, pus cells, casts or other abnormalities. Cystoscopic examination was not performed at any time and a urologist was not consulted. This unscientific attitude was the result of observation of urologists, who seemed to be a tribe of men, very skilled with their hands, but who couldn't think without first inserting a large instrument into a sensitive, partially anesthetized urethra.

Musculoskeletal System

Aching in the back and extremities appeared occasionally and was never severe until after pushing a car out of a mudhole. Back pain of severe, recurrent nature then appeared. On consultation with a clinic known in all parts of the world, he was referred to the orthopedic section. An orthopedic surgeon made a diagnosis of unstable back, on the basis of x-ray findings and advised a fusion of the lower back.

At this time, the physician, aged twenty-eight, was in practice and could not afford to stop his income. A physician in the clinic, interested in joint diseases, found some nodules in the lumbar muscles, made a diagnosis of *fibrositis* and immediately improved the back pain by infra-red rays and massage.

Nose

His nose would become obstructed at times, without any evidence of an upper respiratory infection. When lying down at night, one nostril was usually obstructed. When visiting a university medical school, the aching became more severe than usual. X-rays revealed a diffuse haziness of both frontal sinuses, interpreted by the assistant radiologist as *sinusitis*.

While in the armed forces, he visited a New York teaching hospital about his head pain and sinuses. The chief of the outpatient department advised resection and straightening of the somewhat deviated nasal septum.

General History

Aside from the above symptoms, he was considered perfectly well, indulged in outdoor sports and lived a normal life. All laboratory examinations and other x-rays were normal. There were no other signs or symptoms. His family history was essentially negative, a long lived family without malignant tumors, heart disease, tuberculosis or other severe chronic condition. His mother would feel uncomfortable after eating nuts. Myopia directly descended from the mother to the three children. His father had a chronic nasal condition characterized by attacks of purulent sinusitis and recurrent bronchitis.

Discussion

The cause of his symptoms could have been recognized at any time by taking a history. Can you recognize it? As you will note, it must be a relatively benign condition which occurs time after time without leaving marked pathologic changes.

(To encourage readers to think, the editors will send a medical book to all who send in the correct diagnosis. A *Clinical Medicine* symposium will be sent to all readers who submit an answer. Write to Clinical Medicine, Professional Building, Waukegan, Illinois, stating "my diagnosis is ————————." The solution will be published in two months, together with names and addresses of those submitting the correct diagnosis).

Modern Treatment of Pneumonia

Gordon J. Kaske, M.D. (*U. S. Naval Medical Bulletin*, May 1946) summarizes 1,200 cases of pneumonia without a death:

1. Both sulfadiazine and penicillin given together greatly shorten the course of the disease. Penicillin is given intramuscularly in doses of 20,000 units on admission and 10,000 or more units, every 3 hours thereafter.

Sulfadiazine is given in doses of 2 to 4 Gm. (30 to 60 gr.) with an equal amount of sodium bicarbonate on admission, if the white blood count is over 10,000; sulfadiazine and sodium bicarbonate, 1 Gm. (15 gr.) of each every 4 hours day and night, is given unless the white blood count drops below 10,000 or the urine reveals sulfonamide crystals, blood or albumin.

2. 1,000 cc. of physiologic saline solution with 5 percent dextrose are given intravenously for high fever or dehydration. Fluids are given freely by mouth; Intake and output of liquids are recorded.

3. Oxygen tent, mask or nasal catheter are administered if cyanosis, tachycardia faster than 120 beats per minute or dyspnea occur.

4. Morphine sulphate in doses of 1/6 gr. for severe pain or restlessness or severe cough, or codeine sulfate 1 gr.

5. Red blood cell counts and blood protein determinations are made on all seriously or critically ill patients. Whole blood or plasma transfusions are administered freely and *early* in the course of the disease, to relieve deficiencies.

6. Regular determinations of blood sedimentation rate to determine when a patient has improved enough to be ambulatory.

EDITORIALS

The Office Assistant

The well trained office assistant doubles the amount of time that the physician can give to his patients, and halves the time consuming details.

She greets patients, sees that they are seated comortably, gets out their records, answers the phone and thus detours many minor calls that take up the physician's time.

She obtains the first portion of the history, address, and in some cases, the presenting symptoms. If tactful, she can explain the reason for disputed charges, give exact details concerning the physician's orders and smooth over many rough spots.

She keeps a record of all patients and jots down future calls as scheduled so that too many patients will not have appointments on the same day.

She keeps all bills, accounts payable, pays minor bills, and sees that statements are sent out regularly.

She assists the physician during dressings, minor operations and treatments.

She assists women patients to undress, drapes them for examinations, and stands by during that time.

She tests urine for sugar and albumin. With training, she can perform blood counts.

She administers ultraviolet and infrared rays, and diathermy, under supervision.

She develops x-ray films.

The Peckham Experiment

"A Study in the Living Structure of Society" is the title and a summary of a small volume.* The Peckham experiment involved the building of a physical plant in one section of London. Far more important, it involved the mental approach of physicians, biologists, physical educators and others interested in life, health and disease. This group became interested in the family as a basic unit of society, gave health examinations (more complete and different from the usual examination for disease) and offered "family consultations" in which all problems were discussed, often before they became serious. In this club for the living, all phases of life are emphasized, including swimming, sports, dancing, quiet recreations, instructions in home methods and so on, so that an entire family can be happy. This is *civilized* living.

* Pearse, Innes and Crocker, Lucy: "The Peckham Experiment." George Allen and Unwin, Ltd., 40 Museum Street, W.C., London, England Fifth Impression, 1944.

Problems in Practice

(Questions and Answers)

Streptomycin in Diarrhea

Question: Is streptomycin of value in severe diarrhea?—M.D., Illinois.

Answer: There are several reports in the literature that would indicate that oral streptomycin is of considerable benefit in the management of specific types of dysenteries. It has been found effective in doses of 1 to 4 gms. daily for 8 days in cases of diarrhea due to Shigella sonnei and Shigella flexneri. *Dysentery bacilli were to disappear from the stools with clinical improvement in nearly every case.*

Early clinical reports would indicate that streptomycin by mouth is not beneficial in salmonella infections (Ref. 2). The value of streptomycin in infectious diarrhea is questionable and there is not sufficient evidence as yet to state whether or not it is beneficial.

The Children's Hospital of Washington, D. C., at the present time is evaluating the use of streptomycin by mouth in infectious and non-specific diarrheas of infants and children under the sponsorship of the Research Grants Division of the United States Public Health Service. This 12 month study which was started on July 1st is under way at the present time and no conclusions can be drawn on the basis of our present evidence as to the value of streptomycin in the management of these cases. It seems pretty clear that there is considerable inhibitory effect on the bacterial flora of the intestinal tract but whether or not the clinical course of diarrhea will be altered remains to be seen.—FREDERIC G. BURKE, M.D., Washington, D.C.

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Labor With Amputated Cervix

Question: May labor be permitted to proceed in a woman who has had a high amputation of the cervix?

Answer: The best answer to this question is that published in the Journal of the American Medical Association for Sept. 13, 1947.

Contrary to former ideas, Danforth has pointed out that the cervix is largely fibrous tissue containing few muscle cells. Partial removal of this structure need not interfere with normal labor mechanism. If a portion of the cervix remains and there is little scar tissue present the cervix may undergo normal effacement and dilatation. However, when the cervical amputation has been sufficiently complete so that no vaginal portion is present, labor is less likely to pursue a normal course. Furthermore, premature delivery is a fairly common occurrence following high cervical amputation.

The conduct of labor in a patient

who has had an operation on the cervix should be conservative but the prognosis guarded. In the absence of any other contraindication to delivery through the pelvis the patient should be allowed to go into labor and the course followed intelligently. If effacement and dilatation proceed normally, delivery from below can be expected. On the other hand, if after a good test of labor the cervix fails to dilate normally, cesarean section should be considered. Previous plastic surgery for the correction of cystocele and rectocele in addition to cervical amputation should be considered sufficient indication for an elective cesarean section. Spontaneous rupture of the uterus is a rare sequela following surgery of the cervix.

Possible Gallbladder Disease

Question: What about the middle-aged patient who may have gallbladder disease? In some cases, the x-ray indicates that the gallbladder is not emptying properly, in others the x-ray does not show any sign of disease. I realize that all stones should be removed because of future complications occurring when the patient is older and less able to stand severe complications or surgical procedures.—M.D., Chicago.

Answer: Most patients who think that they have gallbladder disease actually have a poorly functioning colon. The type of distress may be very similar. True gallbladder colics are something else again and always necessitate surgical treatment.

"*If there is no pain in the abdomen at any time, do not make a diagnosis of gallbladder disease.* Bowel distress, including poor function of the colon (over use of cathartics or roughage, spastic colon and other nervous manifestations) and lack of hydrochloric acid in the stomach must be carefully ruled out before diagnosing cholecystitis. Recurring colic fully justifies cholecystectomy." (University of Minnesota Medical School)

Burning on Urination

Question: A woman of 27 complains of recurrent burning on urination. Repeated examinations show a normal urine or occasionally a few white cells. The usual urinary sedatives such as pyridium, methylene blue give only temporary relief. She refuses cystoscopy. What may the cause be and what can be done about it?

Answer: Look at the cervix. In almost three-fourths of women with urinary complaints, or even with true pus in the urine, an infected cervix is found. Daily hot douches with vinegar (3 tablespoons in a quart of hot water) will give immediate help. Then after a few days, the cervix should be cauterized, either with a simple cautery, electrocoagulation or chemically with repeated applications of strong silver nitrate solution or Arzol silver nitrate applicators. Cauterization makes these women feel better within a day or two. About five or six weeks is needed before regeneration of the mucosa takes place and a normal cervix is obtained.

An occasional man or woman has urinary burning and possibly a small amount of urethral discharge when they have eaten some food to which they are allergic, or have taken a drug to which they are sensitive.

Clinical Notes and Abstracts

Anemias in Infancy and Childhood

Classification:

1. Anemia secondary to infection
2. Dietary anemia (nutritional or alimentary anemia)
   Iron deficiency during:
   (a) Prenatal period
   (b) Postnatal period
3. Physiologic anemia of prematurity
4. Congenital and familial anemias:
   (a) Congenital hemolytic jaundice
   (b) Sickle cell anemia
   (c) Mediterranean anemia
5. Erythroblastosis (acquired hemolytic states)
6. Primary diseases of the blood
   (a) Aplastic anemia
   (b) Purpura
   (c) Hemophilia
   (d) Leukemia
   (e) Lymphoblastomá (Hodgkins disease, lymphoma, etc.)
7. Anemia secondary to hemorrhage
8. A. Anemia associated with chemical poisons, such as benzene, lead, acetanilid and sulfonamide compounds
   B. Anemia associated with parastic infection
   C. Anemia associated with neoplasms

—JAMES M. BATY, M.D. in *J.A.M.A.*, July 19, 1947.

1. *New born infant:* Hemolytic anemia (erythroblastosis fetalis) due to Rh factor, should be treated with Rh-negative blood transfusions in doses of 10 cc. of blood per pound of body weight at one time, until the red cells number at least 3 million and the hemoglobin 8 Gm. If Rh-negative blood is not available, Rh positive blood may be used if the plasma is separated and the red blood cells washed and resuspended in isotonic sodium chloride solution.

Whenever patients require several transfusions, blood Rh typing should be done.

Prophylactic administration of vitamin K to mother and infant will prevent hemorrhagic disease of the newborn (hypo-prothombinemia neonatorum).

Hemorrhage due to slipped cord ligature or trauma should be replaced by transfused blood. Asphyxia should be avoided in the newborn to decrease incidence of hemorrhage. Hemophilia, congenital thrombocytopenic purpura and infection are treated with transfusions (plus chemotherapy for infection).

2. *Anemia in infants* is usually due to iron deficiency, to infection, chronic inflammation, deficient diet or neoplastic disease (and to maternal anemia during pregnancy). Iron should be administered:

Rx Ferrous sulfate	9.0 cc.
Spirit peppermint	1.0 cc.
solution amaranth	1.0 cc.
solution citric acid	60.0 cc.
syrup citric acid to make	120.0 cc.

(4 cc. or 1 dram contains 2.5 gr. or 0.16 Gm. ferrous sulfate).

Sig. 2 teaspoons daily for infants; 4 or 5 daily for children.

If anemia does not respond to such therapy and to a balanced diet, one should rule out infection, chronic inflammation or neoplastic disease, then give copper, liver or liver extract, and vitamin C.

3. *Anemia in children* is due to nutritional deficiency, chronic infection, chronic inflammatory disease or loss

of blood. Streptococcic infections and their complications, pyogenic infection, chronic sinusitis, pneumonia, nephritis, rheumatic fever, tuberculosis and symptomatic purpura are common. Menstruation causes an iron deficiency anemia in girls.—H. G. PONCHER, M.D. in *J.A.M.A.*, July 19, 1947.

Paradoxical Problems of Syphilis

Syphilis is peculiarly disposed to some human tissue and avoids others. Bone, the endothelial lining and musculature of blood vessels, and the brain, liver, and testes are particularly susceptible, but thyroid, pancreas, kidney, and ovary are practically immune.

Squamous epithelium is readily infected, columnar epithelium is not. The pharynx is a common site, but the stomach is rarely, and the intestines never, involved.

Testes are frequently infected. Ovaries rarely so. Syphilis in the maternal patient is milder than in the nonpregnant women—yet syphilis gravely affects the fetus. The smooth muscle of the uterus is often involved, but the anterior and posterior vaginal walls are the one example of resistant squamous epithelium.

In the central nervous system, gray matter degenerates in paresis, with heavy infestation of organisms; the white matter is affected in tabes, but spirochetes are not seen. In asymptomatic neurosyphilis, abnormalities of the spinal fluid may reveal serious nerve tissue damage.

Tabes commonly affects the weak individual and paresis the strong. Conjugal syphilis may be tabetic in one partner and paretic in the other.

Syphilitic changes occur at the base of the aorta, and frequently extend to the aortic valves but rarely cause major coronary occlusion.

Congenital syphilis may be unsuspected for long periods, with the initial symptoms following another disease, accident, or pregnancy. The congenital form differs in many ways from the acquired. Interstitial keratitis may be so resistant that during vigorous treatment a previously normal eye becomes infected. Juvenile paresis is frequent, tabes extremely rare. The only congenital cardiovascular abnormality is occasional valvular defect, usually not diagnosed until autopsy.

Virus pneumonia, poliomyelitis, malaria, varicella, leprosy, yaws, pinta, and many other diseases may give positive flocculation and complement-fixation reactions. Serologic reactions may not be indicative until six weeks or more after initial infection or may be negative for years, then become positive with or without evidence of relapse.—UDO J. WILE, M. D. (Univ of Mich., Ann Arbor) in *Proceedings Inst. of Medicine*, Chicago, 16:246-251, 1946.

Effects of Carotid Sinus Stimulation on Tachycardia

The carotid sinus "test," i.e., mechanical stimulation of the sinus, is useful in the differential diagnosis of certain cardiac arrhythmias characterized by tachycardia. For tachycardias with a normal basic rhythm, the effect of carotid sinus stimulation is as follows:

	Paroxysmal Auricular Tachycardia	Normal Tachycardia	Auricular Flutter
Attack Stopped Suddenly	yes	no	no
Temporary Slowing Ventricular Rhythm	no	?	?
Ventricular Rate Halved Suddenly	no	no	no

In the tachycardias with irregular rhythm, carotid sinus stimulation slows the ventricular rate temporarily in auricular fibrillation, though the ventricular rhythm remains totally irregular, and has no effect upon ventricular tachycardia. —S. A. LEVINE, "Clinical Heart Disease," (Saunders) 1945.

Mental Depression Due to Protein Deficiency

Mental depression which may progress to apathy, confusion, and incontinence of urine and feces, anorexia, weakness and lassitude may be due to a protein deficiency. These are not normal consequences of the post-operative state or of patients who are undergoing

a severe illness. Nothing is so striking as to see these symptoms disappear in a few days of a program of high feeding. With the use of Baxter's Protein Solution intravenously, combined with glucose, salt and vitamins, complete parenteral feeding can be achieved for short periods of time, or with unusual attention, up to three weeks. This feeding has the advantage of producing complete gastro-intestinal rest, equal, if not superior to that induced by morphine. Parenteral feeding is used to supplement the oral intake in patients with severe anorexia.

The oral preparation of *protein hydrolysate* is more advantageous. It may be given by stomach tube, if necessary. Five to ten units of regular insulin injected shortly before feeding will create the sensation of hunger and is a valuable adjuvant in the treatment of anorexia. High protein feeding may cause distention and diarrhea. In persistant cases, relief is obtained by slow increase of protein intake and by the use of aluminum hydroxide or paregoric. H. Springs, M. D., *Med. Clinics North America*, March, 1946.

Value of Accurate Bacteriologic Diagnosis

Whenever possible, accurate bacteriologic examinations are always advisable in relation to penicillin and streptomycin in therapy, since the administration of these compounds is indicated only in the susceptible organisms.

They are also indicated when mixed infections are suspected, as in lung abscess, empyema, bronchiectasis, sinusitis, chronic wounds, etc., since mixed treatment with penicillin and streptomycin may be indicated.

In many instances, however the physician or surgeon is justified in making a presumptive diagnosis on the basis of the signs and symptoms presented and proceeding with penicillin or streptomycin therapy without further delay. Indeed, in many of the severe infections like the septicemias, suppurative meningitides, pneumonias, acute osteomyelitis, etc., treatment should be instituted as soon as possible since it can be stopped, with no penicillin or streptomycin therapy.

Tests for Abnormal Bleeding

If a patient states that he is a "bleeder" ask specifically about the outcome of previous operations, tooth extractions, traumatic accidents, the need for transfusions, duration and degree of menstruation and a family history of bleeding.

Physical examination: Look for ecchymoses, especially when non-tender and in skin overlying bones near the surface, petechiae about the ankles, suffusions of blood into the mucosa of the mouth, blood crusts about the nose, lips, gums and posterior pharyngeal wall. Swellings and partial ankyloses of joints may represent previous or present hermarthoses. Lymphadenophathies, enlarged spleen and liver may suggest disorders like leukemia, cirrhosis of the liver and Banti's syndrome, all of which may be accompanied by abnormal bleeding.

Functional Tests

Normal results do not exclude a bleeding tendency but merely mean that it has not been demonstrated.

Bleeding time: A patient with a persistently prolonged bleeding time should be considered a potential bleeder. (minimum time for bleeding from a cut is 0 seconds; average 2 minutes, high normal 6 minutes; every 15 seconds the bleeding spot is touched with filter paper).

Petechial reaction: Application of a blood pressure cuff to the upper arm and compression at 50 mm. of mercury, for a number of minutes, when productive of numerous petechiae probably represents a hemostatic defect. A negative test is uninformative.

Coagulation time of venous blood in glass tubes shows a normal of 11.5 minutes. If the reading is less than 7 minutes the blood is hypercoagulable; if over 15 minutes, it coagulates abnormally slowly.

Blood prothrombin may be measured by thromboplastin solution (commercially available) in a bedside test, determining the time required to produce clotting when this substance is added to 1 cc. of blood being taken as the standard. If the patient has less than 25 percent of normal of prothrombin, it may be clinically important.

Blood platelets may be roughly estimated by noting on a well made, well stained blood smear, if at the edges and beginning of the smear, there is a rough proportion of platelets to red blood cells of 20 to 1. A patient with a platelet count of under 75,000 should be considered as a potential bleeder.

Clot retractions: Normally, between 60 and 90 percent of serum contained within the clot will be expressed. If the clot retracts poorly or not at all, at 37° C. within 2 hours after it is formed, one or more defects are probably present.

Hypercoagulability may be a reaction to a recent hemorrhage.—LEANDRO N. TOCANTINS, M. D. (Jefferson Medical College, Philadelphia) in *Med. Clin. N. Amer.*, Nov. 1946.

Penicillin Ointment for Impetigo

Greasy ointments are unsatisfactory for the treatment of impetiginous skin lesions in hot climates. The following water-soluble ointment was used in the Navy with success:

Rx Tragacanth	20
Glycerin	200
Water	200

Mix the tragacanth with 30 cc. glycerin and add to the remainder of the glycerin. Add to this 100 cc. of water and mix. Add 100,000 units penicillin to the remainder of the water and mix the whole thoroughly. Apply locally at least three times daily after new vesicles have been broken with cotton applicators dipped in 10 percent silver nitrate solution.—W. B. BRETT, *Naval Medical Bull.*, 46, 9, 1439, 1946.

Treatment of Penicillin Urticaria

Urticaria is the most common allergic response encountered in penicillin therapy. Relief of pruritis in a matter of a few hours and disappearance of all allergic manifestations within twenty four hours can be obtained by the intravenous administration of nicotinic acid in doses of 35 mgms. in 10 cc. distilled water. The injection should be made slowly and a pause made after several cubic centimeters have been delivered to allow the flush and subjective symptoms to subside before completing the administration.—W. C. SERVICE, *Annals of Allergy*, 397, Sept.-Oct. 1946.

Para-Amino-Benzoic Acid for Rickettsial Diseases

In Rocky Mountain spotted fever, scrub typhus and typhus fever, one should use para-amino-benzoic acid in large enough doses to keep up an adequate concentration of the drug in the blood of the patient. Rickettsial diseases should be treated with varying doses of para-amino-benzoic acid, a relatively non-toxic medication. The following concentration of the drug in the blood should be effective in the following diseases:

Rocky Mountain Spotted Fever	10-20 mgms. present
Marine (endemic) Typhus	10-20 mgms. present
Epidemic Typhus	15-25 mgms. present

The use of these doses may result in a mortality rate of practically zero in a series of cases of spotted fever. To determine the blood levels of para-amino-benzoic acid, one employs the sulfonamide method by using a para-amino-benzoic standard instead of sulfonamide standard for this determination.—PERRIN H. LONG, M.D., Baltimore, Md., from notes of Omaha Mid-West Clinical Society Meeting, 1946.

Treatment of Psoriasis

The effect of arsenic on psoriasis does not warrant its prolonged administration, and under no circumstances without a strict supervision by the medical attendant. If arsenic is given at all, and there are many chronic cases in which the response is satisfactory, the physician should administer it himself by intramuscular injections, and in the form of sodium cacodylate (gr. 2-5 with or without salicylate of mercury as in Enesol) twice weekly.

Intramuscular injections of manganese (psorimangan) or terpichin—a German turpentine preparation are, sometimes, very effective. Aolan (3-5 c.c.) or boiled milk (5 c.c.) injections are quite safe and have proved effective in controlling the rapidly spreading case in my experience. Just as in atopic eczematous cases and dermititis generally, it is well worth a trial and appears to have no contraindications. The injections are given two or three times a week, deeply into the glutei muscles.— H. C. SEMON, M.D., in *Med. World* (Eng.) July, 1947.

Treatment of Cardiac Failure

The dose of 1.2 mgms. of digitoxin given at one time and followed by the daily dose of 0.2 mgms. for maintenance has simplified the problem of digitalization in the average patient with cardiac failure. In adjusting the dose for patients who have already been receiving digitalis it must be remembered that digitoxin is 1000 times as potent as the current U.S.P. digitalis by oral administration (0.1 mgms. digitoxin-0.1 gms. digitalis).—HARRY GOLD, M.D. Modern Concepts Cardiovasc. Diseases, Nov. 1945.

Simplified Hemoglobin Determination for Blood Donors

A solution of copper sulphate of specific gravity of 1.052 is used. If a drop of blood sinks immediately, when dropped in this solution, its specific gravity is greater than 1.052, and this indicates a hemoglobin concentration of 12.3 grams or more for 100 cc of blood. This is the minimal acceptable level of hemoglobin. If the drop of blood does not sink immediately, the hemoglobin content is insufficient to allow a donation of blood. —WILLIAM THALHEIMER, M. D., in *American Journal of Surgery*, Sept. 1946.

Ultraviolet Treatment for Herpes Zoster

Herpes Zoster may be treated with erythema doses of ultraviolet. No other treatment will be necessary except for a mild analgesic. A rapid relief of pain, drying up of the eruption and the neuritis that so often follows occurs with ultraviolet therapy. — G. E. CROSLEY, M.D., in *Burdick Syllabus*, Feb. 1947.

Emotional Control in Heart Disease

There are three therapeutic measures which are superior to drugs. They are: 1. emotional control; 2. rest and 3. exercise. Unless the patient can be taught to acquire emotional control, the other two measures will be largely inoperative.—E. KEATING, M.D. in *Prescriber* (Eng.), Sept. 1946.

Reactions from Intraspinal Penicillin

Penicillin may be given intraspinally in doses of 10,000 units at a time; rarely more than 4 intraspinal injections are necessary. There were no reactions in a series of 72 cases of all types of meningitis, with cell counts up to 50,000. The injection of larger doses of penicillin may result in spinal cord injury and flacid paralysis below that level. —T. G. ERICKSON, M. D., in *J.A.M.A.*, Nov. 9, 1946.

Meat for Infants

One ounce of strained meat daily added to the diet of 6 weeks old infants prevents the usual hemoglobin drop in later infancy and promotes the formation of additional hemoglobin and red blood cells.—GEORGE CLARK, M.D. in *J.A.M.A.*, Aug. 9, 1947. (Canned, strained meat is now commercially available.—Ed.)

Penicillin With Procaine

To relieve the discomfort of penicillin injections, aspirate 1 cc. of procaine (Novocaine) solution into the syringe with the penicillin solution, and inject. Thus the local aesthetic precedes the penicillin into the tissues.—A. FLEMING, M.D. in "Penicillin" (Blakiston).

Undiagnosed Infection in the Newborn

The newborn infant, particularly the premature infant, appears to be extremely susceptible to infections and these may manifest themselves in an obscure fashion. Fever is often absent; high fever in such infants is uncommon. Limpness, apathy, a poor color, failure of the infant to take feed, diarrhea or vomiting, may be the only symptoms.

Look for infection in: 1. upper respiratory tract; 2. umbilicus; 3. skin, and 4. the alimentary tract.

A generalized blood stream infection may result from any of these sites, due to the neonate's poor ability to localize its infection. Obtain material from eyes, nose, throat, nasopharynx, rectum and other obvious sites of infection; a culture may be necessary.—DONALD PATERSON, M.D. in "Penicillin" by FLEMING (Blakiston).
Sept. 21, 1946.

Gynecomastia (Male Breast Enlargement)

An analysis of 284 cases of gynecomastac, the majority in the third decade, revealed that 95 percent presented unilateral lesions. No definite cause was demonstrated except for the bilateral cases associated with tumors of the testis or after administration of synthetic estrogens. Pathologically there is epithelial proliferation of the ducts, increased number of ducts, increased fibrous tissue, failure of acini formation and inflammatory infiltration by mononuclear cells. There is no definite evidence that neoplasia supervenes. — H. T. KARSNER, *Amer. J. Path.*, 22, 235-297,

Riboflavin for Eye Symptoms

Sensitivity to light, tiredness of the eyes, aching eyes, sandy sensation under the eyelids, reading intolerance and decreased visual acuity, in the absence of organic disease may be relieved or cured by riboflavin in doses of 5 mg. three times daily, or oftener. (Riboflavin is a constituent of the vitamin B complex; it is a pure synthetic vitamin, known in the past as vitamin B_2 or G. Its deficiency may be recognized by a violet-colored conjunctival congestion, by lesions of the lips, tongue, nose and skin.—Ed.) C. B. SMITH, M. D. in *Canadian M. A. J.*, June 1946.

Cannabis Indica Hallucinations

The ingestion of 20 to 30 minims of cannabis indica (U.S.P.) results in hallucinations for a number of hours, usually of a pleasant nature. The next day, the subject feels elated.—VICTOR ROBINSON, M.M. in *Ciba Symposia*, Aug. Sept. 1946. (This drug has a place in the treatment of advanced, inoperable malignant tumors for masking pain and reality.—Ed.)

Premature Delivery

Premature delivery may be due to toxemia, including hypertension and renal disease, multiple pregnancy, syphilis, placenta previa, premature separation of placenta or premature rupture of the membranes.

Treatment: Spontaneous delivery, with low forceps if indicated, and episiotomy. Give no morphine to mother. The infant should be given oxygen, as soon as mucous is sucked from throat, and an injection of Vitamin K.—ETHEL S. DANA, M.D., in *Am. J. Ob. & Gyn.*, March, 1946.

A History of the American Medical Association (1847-1947)

By Morris Fishbein, M.D. With Biographies of the Presidents of the Association by Walter L. Bierring, M.D.—W. B. Saunders Co. 1947. $8.00.

It is fitting that the one hundreth anniversary of the American Medical Association be celebrated by this magnificent and readable volume. The text is well organized, written in smooth style, with little personal bias and with an amazing chronologic coverage of events. One understands the "A.M.A." better as one learns significant points in its history. Important libel suits against the association and individuals are well portrayed.

Recent Advances in Clinical Pathology

By Various Authors, Under the Auspices of the European Association of Clinical Pathologists.—Blakiston Co. Press. 1947. $5.50.

A series of independent articles portraying the growing field of clinical laboratory diagnosis and management of clinical conditions requiring exacting laboratory cotrol. Sufficient details are given so that all procedures can be carried out directly from this work. The various authors concerned have performed their tasks well, in the fields of bacteriology, biochemistry, hematology and histology.

A Symposium on the Blood

University of Wisconsin Press. $3.50.

A tremendously interesting volume concerning the various aspects of the blood and its diseases, presented by 15 investigators and clinicians.

Calcific Disease of the Aortic Valve

By H. T. Karsner, M.D., and Simon Koletsky, M.D., Western Reserve University, Cleveland.—J. B. Lippincott. 1947. $5.00.

A monograph, including clinical and postmortem studies, concerning calcification of the aortic valve. The photographs are very well done.

Recent Advances in Endocrinology

By A. T. Cameron, C.M.G., M.A., D.Sc., (Edin.), F.R.S.C., Biochemist, Winnipeg General Hospital, Canada.—Blakiston Press. 1947. $6.00.

A very adequate short survey of the recent work in the field of glandular diseases, for the man especially interested in that field, complete with case reports.

Fundamentals of Psychiatry

By Edward A. Strecker, M.D., Professor of Psychiatry, University of Pennsylvania. —J. B. Lippincott. 1947 4th Ed. $4.00.

A wealth of some the most interesting data on psychiatry may be found in this volume.

Hospitals: Integrated Design

By Isadore Rosenfield. Progressive Architecture Library.—Reinhold Publishing Corp. 1947. $10.75.

A beautifully printed, large volume containing hundreds of floor plans and photographs of hospitals, their facilities and how they may best be planned for. The author has made a careful study of the literature, referring to hospital construction. It is unfortunate that he did not make as careful a study of the situation in regard to hospital care, and thus could have shortened the volume by omitting propaganda on socialized medical care. Again he steps out of his field by stating that contagious cases should be cared for only in large contagious disease hospitals; the trend is against this. When he confines himself to his own experience, he presents many admirable ideas. The book should be of great value to those planning a hospital, to hospital superintendents and to physicians interested in hospitals.

Gifford's Textbook of Ophthalmology

By Francis H. Adler, M.D., Professor of Ophthalmology, University of Pennsylvania Medical School, Philadelphia. Saunders. 1947. $6.00.

This text on examination of the eye, the recognition of its disorders and their management is written expressly for the general practitioner, who is often the first physician consulted. The material is well written and illustrated; many helpful hints are given as to practical management of minor conditions.

Actions and Uses of Drugs

For Medical Students and Practitioners. By Norman Sapeika, M.B., Assistant, Department of Pharmacology, University of Cape Town, South Africa.—Post-Graduate Press. 1946. $5.50.

The text is laid out in easily grasped classifications, according to the action of each drug considered. Each drug is presented under the various topics concerning its composition, actions both general and local, and uses. Because of its brevity of presentation, it is a handy manual for students, internes and other younger medical personnel.

Atlas of Cardiovascular Disease

By Irving J. Treiger, M.D., Assistant Professor of Medicine, University of Illinois, Chicago.—C. V. Mosby. 1947. $10.00.

Just the book for the average physician who says, "I really must brush up my knowledge of the heart." The author presents his material in telegraphic style without any long discussions or other distracting elements. The essentials of the normal X-ray and electrocardiogram are shown in photographs, the variations in the normal displayed and then a series of clinical case histories covering each cardiac disorder together with tracings, X-rays, and photographs of the autopsy findings. A beautifully printed and usable book.

The Second Forty Years

By Edward J. Stieglitz, M.D., F.A.C.P. J. B. Lippincott. 1947. $2.95.

This is a scientific presentation for the layman of the biological facts associated with aging. It is presented simply enough to be comprehensible to the layman and even interesting to him at times. He is likely to find the second chapter, The Biology of Senescence, a bit complicated, but if he perseveres in attempting to comprehend this chapter, he will be rewarded with a much clearer understanding of the remaining chapters.

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This book should be of value in allaying many of the apprehensions of those approaching the forty year mark and should offer encouragement to those entering this phase of life with some physical handicap.

Encylopedia of Psychology

Edited by Philip L. Harriman.—Philosophical Library. 1947. $10.00.

Distinguished contributors give the reader an orientation and basic information in the related fields of psychology, psycho-physiology, educational psychology, psychoanalysis, psychiatry, radio research and commercial aspects. It is stimulating to pick the book up and glance at any one of the subheading contents.

On Understanding Science

By James B. Conant, President of Harvard University.—Yale University Press. 1947. $2.00.

A clear story of science for an adult of average intelligence, as illustrated by several typical stories of advances in scientific study and experimental demonstration.

Clinical Hematology

By Maxwell M. Wintrobe, M.D., Professor of Medicine, University of Utah School of Medicine, Salt Lake City.—Lea & Febiger. 1947. 2nd Ed. $11.00.

A comprehensive presentation of diseases of the blood, their recognition and management. The author's advances in more routine and exact measurements are given.

The Measurement of Nervous Habits in Normal Children

By Willard C. Olson, Ph.D., Director, Child Research Development, University of Michigan.—University of Minnesota Press. $2.00.

Approximately seven hundred apparently normal Minneapolis children were studied as to such habits as nail biting, thumb sucking, tics, and so on. The author's conclusions are interesting and important. His preface, in which he quotes various sources for etiological material, seems irrelevant in a basic study.

Physical Medicine in General Practice

By William Bierman, M.D., Assistant Clinical Professor of Medicine, Columbia University.—Paul B. Hoeber (Harper & Brothers). 1947. 2nd Ed. $8.00.

This text on physical therapy, unlike those that result from a disjointed set of papers by specialists in various fields, is a coordinated approach to the various technics and various conditions which benefit by their exhibition. The hundreds of clear illustrations depict exactly the method to be followed.

Yearbook of Endocrinology, Metabolism and Nutrition

Edited by Willard O. Thompson, M.D. Clinical Professor of Medicine, University of Illinois College of Medicine, Chicago, and Tom D. Spies, M.D., Associate Professor of Medicine, University of Cincinnati School of Medicine, Cincinnati, Ohio.—Year Book Publishers. 1947. $3.75.

There is not a field of medical practice in which this splendid collection of abstracts does not intrude. Newer therapy of hyperthyroidism is stressed. Clear illustrations and text present sufficient material for the average practitioner to properly study spermatozoa in cases of sterility. Treatment with folic acid and many other new agents is well presented. Every physician should have this review.

Uterotubal Insufflation

By I. C. Rubin, M.D., Clinical Professor of Gynecology, Columbia University, New York City.—C. V. Mosby. 1947. $10.00. .....

A complete text on the use of insufflation to diagnose and treat the human fallopian tube. The normal anatomy and histology of the tube, pathologic lesions, physiology of the ovary and tube, are described in part one. Technic of insufflation and correlation regarding findings at laparotomy are extensively presented.

Health Instruction Yearbook, 1946

Compiled by Oliver E. Byrd, Ed.D., Assoc. Prof. Hygiene, Stanford University.—University Press. 1947. $3.00.

A masterly abstract service in book form, of important articles in the literature, concerning health, exercise, public health, family health, school health and physiologic problems.

Bone and Bones

By J. P. Weinman, M.D. and Harry Sicher, M.D., University of Illinois and Loyola College of Dentistry, respectively, Chicago. C. V. Mosby. 1947. $10.00.

A fascinating book on the biology of bone, how it grows, how it adapts and is deformed, together with discussions on endocrine, vitamin and mineral influence, healing and death of bone, and skeletal tumors. The illustrations of fractures and their healing are well done. The authors have successfully carried out a joint clinical-pathological-anatomical approach to bone, a tissue and an organ.

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By S. S. Keiner. Meador Publishing Co. 1947. $3.50.

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Patee's Dietetics

Revised by Hazel E. Munsell, Ph.D. and others.—G. P. Putnam's Sons. 1947. 23rd Ed. $3.50.

Foods, nutrition and dietetics—these three are ably presented in textbook form. Principles of nutrition are clearly stated in the first 126 pages. Diet therapy for specific diseases is well discussed, followed by practical applications involved in feeding the sick, recipes, management of various foods stuffs, and finally the various tables needed.

Emotions and Bodily Changes

By Flanders Dunbar, M.D., Med. Sc.D., Ph.D., Columbia University Departments of Medicine and Psychiatry.—Columbia University Press. 1947. 4rd Ed. $7.50.

An immense bibliography with references to the effect of emotions on various organs and systems of the body. The good physician has always been aware that the personality of the patient influenced his physical health.

Arthritis and Related Conditions

Edited by Theodore F. Bach, M.D. University of Pennsylvania Graduate School, Philadelphia.—F. A. Davis. 1947. $6.50.

A well rounded presentation of the arthritis problem. The questionable validity of the sedimentation rate is clearly presented. Intestinal toxemia is mentioned as a focus of infection and simple therapy suggested. Procaine injections in fibrositis are suggested but the technic of finding the trigger points is not given. Emphasis is upon differential diagnosis and treatment.

Useful Drugs

Council on Pharmacy and Chemistry of American Medical Association.—J. B. Lippincott. 1947. 14th Ed. $2.00.

This is a selected list of essential drugs with a brief discussion of their actions, uses and dosage. A paragraph or two presents the medication and clearly states its place in therapy. A readily used drug reference.

Synopsis of Allergy

By Harry L. Alexander, M.D., Professor of Medicine, Washington U. Medical School, St. Louis.—C. V. Mosby. 1947. $3.00.

Contains many helpful points in the recognition and treatment of allergic diseases. The author emphasizes that skin tests are of limited value, in the recognition of offending allergens. He does not believe that vaccines are of value in the treatment of asthma.

Office Endocrinology

By Robert B. Greenblatt, M.D., Director, Sex Endocrine Clinic, University Hospital, Augusta, Georgia.—Charles C. Thomas. 1947. $4.75.

The author presents didactic material and case histories concerning those principles of endocrinology that may be applied in office management of patients with sterility, habitual abortion, menstrual irregularities, and the male and female climacteric.

A Blind Hog's Acorns

Vignettes of the Maladies of Workers. By Carey P. McCord, M.D.—Cloud Inc. 1946. $2.75.

A truly entertaining book written for the average person, telling of the strange adventures of an industrial surgeon, his work in industry and with people. The mystery of Hannah's disappearing skin grafts, of the man who had signs but no symptoms of lead poisoning, the alcoholic saintly physician, the first "detective" job with the tie makers—all these are well worth reading for fun and profit.

Methods of Vitamin Assay

Edited by Association of Vitamin Chemists, Inc.—Interscience Publishers. 1947. $3.50.

Exact technics are given for each vitamin assay. The problem of sampling is discussed and methods of avoiding large variations presented.

Mahan on Sea Power

By William E. Livezey.—University of Oklahoma Press. 1947. $3.50.

Captain Mahan, U.S.N., was a regular navy officer who possessed two habits unusual in regular naval officers—those of study and reflection, and of prophecy. He could write well and publicize his views. In so doing, he indirectly encouraged the concept of sea power as a dominant power in all the major nations of the earth for a period of 30 years. He visualized the possible relationships of Japan, Russia, Britain, France and the United States. The author presents Mahan's evidence, its strength's and weaknesses.

Communicable Diseases

By Franklin H. Top, M.D., Medical Director, Herman Kiefer Hospital, Detroit.—C. V. Mosby. 1947. 2nd Ed. $8.50.

This is the most direct and informative text in its field, for the general practitioner. Its lifelike illustrations of the lesions of the various communicable diseases, including syphilis, are of teaching value. A number of other authorities contribute chapters on specific diseases and their care, including nursing care.

Diseases of the Gallbladder and Allied Structures

By Moses Behrend, M.D., F.A.C.S., Consulting Surgeon, Jewish and Mt. Sinai Hospitals, Philadelphia.—F. A. Davis. 1947. $7.00.

This volume is helpful to the surgeon to review the anatomy of the gallbladder, bile ducts and vessels to the liver and pancreas, because of its many illustrations depicting variations from the normal. The author is very dogmatic in most of his statements, often without giving any more proof than his own word. He delays giving his patients food until the third postoperative day.

Pye's Surgical Handicraft

By Hamilton Bailey, F.R.C.S., Royal Northern Hospital, London, Eng.,—John Wright, Publisher, Bristol, England. 1946. $6.50.

This, the 15th edition of a famous book on minor surgery is a welcome addition to those who perform minor surgery in the office, or hospital.

The hundreds of illustrations illustrate various steps of technic and the appearance of surgical lesions. The text is very much up-to-date with an occasional exception for a typical British custom; for example, the use of the left lateral position for sigmoidoscopy.

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Essentials of Pharmacology

By F. K. Oldham, Ph.D., F. E. Kelsey, Ph.D. E. M. K. Geiling, M.D., Professor of Pharmacology, University of Chicago.—J. B. Lippincott. 1947. $5.00.

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A Safe Walking Iron

Horace G. Scott, M.D. of Minneapolis reports a new type of walking iron which cannot slip when used on smooth floors or ice. Our artist shows the construction of the iron (Fig. 1). A cross bar is placed in front and one behind the central bar, and each tilted at a slight angle so that patients weight always rests on a bar as he walks. By the simple application of a cover with metal teeth, (Fig. 2). the patient has a walking cleat which grips icy pavements.

The device was invented and patented by Kenneth Hahn, himself a patient with a fractured tibia, and is manufactured by him at 4135 Thirty-Ninth Avenue South, Minneapolis, 6. Minnesota, in light alloys.

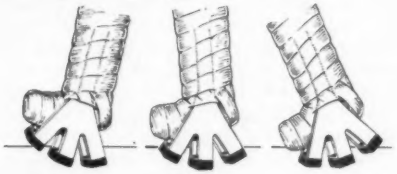

Fig. 1

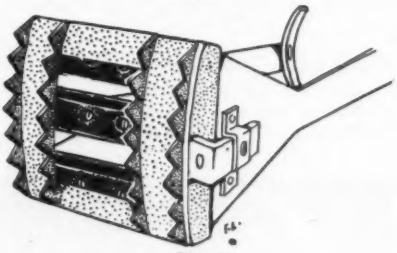

Fig. 2

The Patient's History

Much time can be saved the physician if important aspects of the patient's history are covered thoroughly without asking each question concerning every system of the body. One way in which this can be accomplished is by use of a printed form entitled "Personal Health Inventory," published by Oliver E. Byrd, M.D., Professor of Health Education, Director Department of Hygiene, Stanford University, California.

Specific questions are asked concerning each organ and blank spaces furnished to indicate any symptoms, e.g. Genito-urinary; difficult urination—Pain on Urination—Burning or stinging on

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urination—Do you have to get up at night to empty the bladder—How Many times—Blood in urine—Et cetera. Previous history including diseases, operations, immunizations, accidents, family history of disease, health and dietary habits and progress in school are included.

It is true that history taking cannot be complete without further questioning by the physician but such a form reminds the patient of symptoms that he would otherwise forget and points the way to diseases of other systems than the one being primarily considered. Nutritional deficiency may also be uncovered. The form may be filled out while waiting for the physician. The forms may be ordered from Stanford University.

Accidental Children's Death

Burns are the most frequent cause of accidental deaths of children of all ages. Suffocation caused by blankets or very small playthings caught in the throat takes the lives of hundreds of very small children in the United States each year. — *National Conference on Home Safety.*

Planning to Retire? You'll Be Happier Working

Planning to retire at 65? You'll probably feel better, be happier and live longer if you continue some kind of active work long after you are eligible for retirement, say George Lawton and Maxwell S. Stewart, authors of "When You Grow Older," new Public Affairs $ .20 pamphlet published by the Public Affairs Committee, Inc., 22 East 38th St., New York 16, N.Y.

"Many men and women, successful in business, the arts, or the professions, look forward to their fifties as a time when they flee for asylum to their 'farm,' their ten-acre estate. There they read, do a little gardening, mingle with the natives, and imagine they have learned the lesson of growing old gracefully!"

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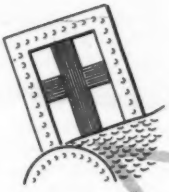

Armor showing ailettes, A. D. 1320

Ailettes, *nothing more than plates of forged iron or steel, were worn over the coat of mail to protect shoulders against blows aimed at the headpiece and glancing off.*

for extra PROTECTION!

JUST as ailettes gave added protection, so does this seal or mention of the Wisconsin Alumni Research Foundation on a product give you extra assurance. For this seal warrants the Vitamin D content. It guarantees that the product is regularly subjected to the Foundation laboratory tests to make certain it meets the high standards and rigid requirements. For almost a score of years the medical profession has advised its patients to "look to the Foundation Seal" with full confidence.

WISCONSIN ALUMNI *Research* FOUNDATION

MADISON 6, WISCONSIN

MEDICAL NEWS

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Actually, according to the pamphlet, this is "How To Grow Old Disgracefully."

While work should be cut down gradually, people need purposeful activity as long as they live for their physical and mental health, say the authors.

"Many older persons seem to be convinced that the problem of old age is chiefly a money problem. For those who are unbable to work, or unable to find jobs, financial security may seem all-important. But it is not as important as it seems."

Because a pension does not and cannot guarantee a person social and recreational activities, the pamphlet stresses the importances of avocations, hobbies and off the job activities.

Despite the housing shortage, oldsters are advised against living with a son or daughter and their family. Chances for this arrangement being mutually satisfactory in the typical American household are about one in a hundred, the authors warn.

Calling for a farsighted program of social legislation to develop adequate institutional facilities for older persons, the authors point to the serious shortages in old-age homes and nursing homes. Most of these homes now are not adapted to real needs of older people.

1. Keep in trim. Play is essential to health. Find the recreation that's best for you.

2. That tired feeling? Best cure; an active daily program.

3. Learn to live on less. With or without a pension you will probably have to learn to live on considerably less income.

4. Cut down work gradually. Everyone needs to "work" as long as he lives but include more time for play, rest, hobbies and off the job activities.

Does it Pay to Work Harder?

In the July, 1947 number of the *Delaware State Medical Journal*, there appeared an item by Wilfred I. King, Ph.D., Professor Emeritus of Economics of New York University, entitled "Does

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for improved muscle function

RELEASE THE BRAKE!

with

PHYATROMINE

Trademark

Physostigmine Salicylate and Atropine Sulfate Injection

A major cause of muscle dysfunction is excessive cholinesterase activity, which inhibits the transmission of cholinergic impulses to muscle fibers. Physostigmine acts specifically against cholinesterase, thus facilitating unhampered response of the neuromuscular mechanism.

PHYATROMINE* presents this potent agent in a form that assures therapeutic benefit with safety. Unwanted muscarinic side-effects of physostigmine are minimized by the action of atropine sulfate.

INDICATIONS: As an aid in the treatment of arthritis and related conditions, bursitis, fibrositis, spondylitis, myasthenia gravis, neuromuscular dysfunction due to trauma caused by surgery, industrial accidents, war wounds, and back sprains.

ADVANTAGES: Prevents or reduces severity of deformities arising from muscle spasm • Relieves pain caused by muscle spasm • Ready-prepared sterile solution convenient to use • Relatively low cost of medication.

FORMULA: Each cc. of PHYATROMINE contains 0.6 mg. of physostigmine salicylate and atropine sulfate, respectively, in a stable isotonic solution of sodium chloride.

SUPPLIED: 30-cc. multiple-dose vials; boxes of 25 1-cc. ampuls.

*Exclusive trademark of Kremers-Urban Company.

KU

Kremers-Urban Co.

ESTABLISHED 1894

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Please send me: Charge ☐ C.O.D. ☐

Professional sample vial of 5 cc. without cost or obligation.

.....30-cc. vials PHYATROMINE @ $6.00 per vial

.....Boxes of 25 1-cc. ampuls PHYATROMINE @ $6.00 per box

(Quantity prices on request)

Name .....

(Please Print)

Address .....

City .....**Zone**....**State**.....

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It Pay to Work Harder?" In the course of his comments on this subject, Dr. King said:

"For the man who earns $4,000 above his exemption, it manifestly pays to work harder and earn $2,000 more, for Uncle Sam lets him keep three dollars out of every additional four that he gains by hustling. The man making $8,000 above his exemption will probably feel it worth while to add $2,000 to his income, for he is still privileged to keep two out of every three added dollars. However, for the man having an income of $15,000 above his exemptions, the worthwhileness of striving to take in another $5,000 raises serious questions in his mind, for, in his case, the Federal Government takes more than half of the added gains. One can hardly expect the man receiving $100,000 to be much interested in doubling his income, for, if he does, he can only keep for his own use one dollar out of every additional seven.

Educating Your Patient: Common Sense Food Knowledge

The National Dairy Council, Chicago 6, Illinois has published a little folder for your patients, "A Business Talk, To The Man Who Likes 3 Meals a Day." It has many common sense pointers on the advisability of not overeating or over exercising. The subject of what he eats is taken up in a humorous way and so cleverly illustrated that he learns without knowing it. Average weights and heights are given.

"An excellent simple presumptive test for routine use in the diagnosis of diabetes."[1]

CLINITEST

THE TABLET *NO-HEATING* METHOD FOR DETECTION OF URINE-SUGAR

SIMPLE TECHNIC—"My experience with Clinitest has convinced me beyond a shadow of a doubt that they are *the simplest* from the technical standpoint . . ."[2]

SELF-GENERATING HEAT—"The reagent tablet, known as the Clinitest Urine Sugar Tablet . . . generates heat when dissolved and the use of externally applied heat is not required . . ."[1]

Clinitest—simple, speedy, compact, convenient—is distributed through regular drug and medical supply channels.

1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

Identification cards for the protection of your diabetic patients now available free upon request.

AMES COMPANY, INC.
ELKHART, INDIANA

THROBBING AND RINGING

A certain chap alarmed because of throbbing in his throat and ringing in his ears, rushed to his doctor, who diagnosed it as appendicitis and ordered immediate surgery. After the operation the throbbing in his throat and the ringing in his ears started all over again. So he went to a specialist who said it was lung trouble and removed one lung. But the symptoms remained the same. After numerous treatments and other operations, the chap was so at his wits end to find the throbbing in his throat and ringing in his ears still with him that he went to a Clinic, where he was told he had only two more weeks to live.

Determined to enjoy his last two weeks on earth, the fellow drew all his money out of the bank and decided he would have the time of his almost-finished life, with the sky the limit. Going to a very exclusive haberdashery, he saw some beautiful shirts at $30.00 each, and ordered 14 so he could have a clean one for each of his remaining days. He insists he wears a 15 collar, the clerk argues 16 is his size. Our hero is adamant and finally the clerk wearily says "OK—I'll give you 15—but I'm warning you, you'll have a terrific throbbing in the throat and ringing in the ears."

The DDT song is: I'd Be Loused Without You.

"Tell me, when did you first notice your addiction to castor-oil?"

GENEOLOGICAL? IS'N IT?

The blue blood is supported by his forefathers; the pauper by his contemporaries; the debtor by his progeny.

Georgia psychiatrists are said to be eating only Southern Freud chicken.

SCAREDY-CATS

Dentist: Have you seen any little boys ring my doorbell and run away?

Policeman: Those weren't little boys—they were grown-ups.

Local care of the

Fissure of puerperal nipple

White's

White

LABORATORIES, INC., Pharmaceutical Manufacturers, Newark 7, N. J.

puerperal nipple . . .

Brougher[1] noted the inadequacy of numerous topical medicaments recommended for treatment of fissured nipples. In contradistinction, he reports that Vitamin A and D Ointment is of marked prophylactic and healing value in the local care of the puerperal nipple: "... gave protective and therapeutic results much better than those obtained by other methods."

Anderson[2], Weissberg[3] and Kunz[4] also have recorded the special advantages of topically applied vitamins A and D in care of the puerperal nipple.

Clinical experience indicates that prophylactic treatment with White's Vitamin A and D Ointment should be instituted at the 7th month of pregnancy, continuing through lactation.

White's Vitamin A and D Ointment provides the vitamins A and D, derived from fish liver oils, in the same ratio as found in cod liver oil, in a lanolin petrolatum base. Pleasantly fragrant, it is ideally suited to nipple care in the pregnant or lactating patient.

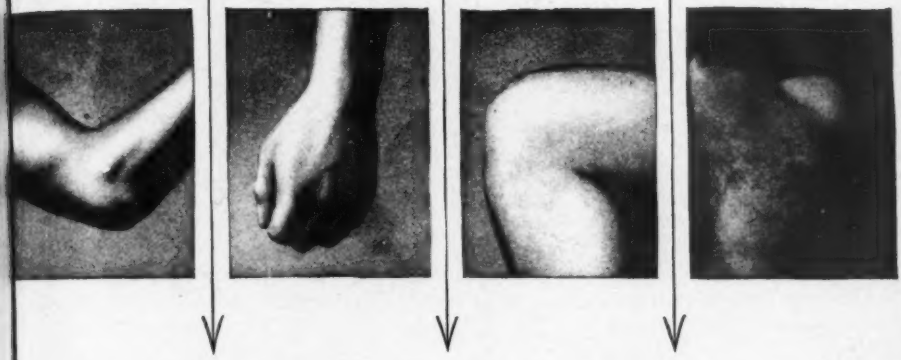
IN 1.5 OZ. TUBES • 8 OZ. AND 16 OZ. JARS • 5 LB. CONTAINERS

1. Brougher, J. C.: West. J. Surg., Obst. and Gyn., *52*:520, 1944.
2. Anderson, H. E.: Local Applications of Vitamins A and D to Nipples of Postpartum Breast, read at meeting of Omaha Mid-West Clin. Soc., 1942.
3. Weissberg, R. S.: Soviet Med., *4*:28, 1940.
4. Kunz, A. C.: Cited by Gunther, M.: Lancet, *2*:590, 1945.

White's *Vitamin* A & D **Ointment**

FOR FASTER HEALING

Beyond the reach of human fingers



eneficial effects may be exerted, not just locally but systemically,
eyond the reach of human fingers" in such conditions as arthritis,
yositis, muscle sprains, bursitis and arthralgia. That systemic
s well as local effects may be achieved by such preparations
Baume Bengué was conclusively demonstrated by the fundamental
ork of Moncorps, Kionka, Hanzlik, Brown and Scott.

LOCALLY — *at the site of discomfort analgesic relief and a beneficial hyperemia may be readily induced.*

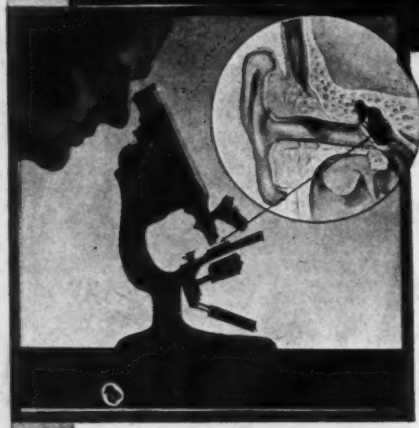
SYSTEMICALLY — *the salicylate absorption promoted by Baume Bengué's methyl salicylate concentration produces systemic effects to reinforce other indicated therapeutic measures.*

Baume Bengué provides 19.7% *methyl salicylate,* 14.4% *menthol in a specially prepared lanolin base.*

Baume Bengué ANALGÉSIQUE

THOS. LEEMING & CO., INC., 155 E. 44th ST., NEW YORK 17, N. Y.

PIONEERS in Research . . . and Leadership thru the years in combating



DOHO in realizing the need for a potent, topical, well tolerated ear medication, yet mindful that no one formula could be suitable for all conditions . . . devoted every facility and scientific resource to the development and perfection of AURALGAN and OTOSMO-SAN. Each has its sphere of usefulness . . . each has been tested and clinically proven in many thousands of cases. *Reprints and substantiating data sent on request.*

EACH A SPECIFIC . . . both effective!

Auralgan
IN ACUTE OTITIS MEDIA

is a scientifically prepared, completely water-free Glycerol (DOHO) having the highest specific gravity obtainable, containing antipyrine and benzocaine . . . which by its potent decongestant, dehydrating and analgesic action provides effective relief of pain and inflammation.

O-TOS-MO-SAN
IN CHRONIC SUPPURATIVE OTITIS MEDIA, FURUNCULOSIS AND AURAL DERMATITIS

is not just a mere mixture, but a scientifically potent chemical combination of Sulfathiazole and Urea in AURALGAN Glycerol (DOHO) base . . . which exerts a powerful solvent action on protein matter, liquefies and dissolves exuberant granulation tissue, cleanses and deodorizes, and tends to exhilarate normal tissue healing in the effective control of chronic suppurative otitis media.

Literature and samples on request

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